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ABSTRACT

In this issue, the Consortium on Early Childbearing and Childrearing, a federally funded research utilization and information sharing project, reports on recent conferences, workshops, and publications pertaining to the problems of young parenthood. The Consortium is directed principally toward helping communities initiate and improve health and social services for school-age pregnant girls, young fathers, and their infants, continuing education services for school-age pregnant girls. The two workshops described in this report had two purposes: to improve the quality of care received by infants in newly instituted alternate care settings; and second, to obtain the clinical experience and observations of those who had been working with young parents and their infants. (CS)

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Sharing

table of contents

SHARING

Editorially Speaking 2

Medical Care: Two New Approaches 3-9

State Conferences: A Report 10

Program Notes 21

Readings 25

SPECIAL SHARING SUPPLEMENT

A summary of two invitational workshops on Improving Care for Infants of School-Age Parents

The Consortium on Early Childbearing and Childrearing...

is a federally funded research utilization and information sharing project being carried out under the auspices of the Child Welfare League of America, Inc. The Consortium's focus is on helping communities throughout the United States establish and improve services to school-age pregnant girls, young fathers, and their infants. Attention is also given to the development of measures aimed at preventing pregnancy in adolescence. The Consortium offers consultation, sponsors conferences and workshops, and distributes publications to those interested in finding solutions to the problems of young parenthood.

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editorially speaking...

The positive outcome of a recent class action suit brought against the U.S. Department of Agriculture on behalf of pregnant and nursing mothers and their infants illustrates the effectiveness of such an appeal by those concerned with mothers and their children. As a result of this suit, U.S. District Court Judge Oliver Gasch has ordered the U.S. Department of Agriculture's Food and Nutrition Service to spend all of the $40 million authorized by Congress for a two-year pilot program which will medically evaluate the effects of adding nutrients regularly to the deficient diets of pregnant and nursing women, infants and children (WIC) in selected low-income areas.

The legislation, in the form of an amendment to the Child Nutrition Act offered by Sen. Hubert Humphrey, D.-Minn., and Sen. Clifford Case, R.-N.J., was passed by Congress last September. The Agriculture Department failed to implement the program, contending that it did not need to spend the full $40 million, that sufficient medical data for the supplemental food program could be obtained through a scaled-down program based on 10,000 women and children rather than the 400,000 women and children envisioned in the legislation. The smaller program would cost only $6 million.

After a year's delay, the Agriculture Department was forced to act when the U. S. District Court ordered that it publish regulations for the program. Following publication of these regulations in the Federal Register on July 11, the Consortium, in cooperation with The Children's Foundation, a public, nonprofit child advocacy group, sent a memorandum to all comprehensive programs on its mailing list alerting them to the existence of the WIC Program and urging them to submit applications for the program and to contact their state and local health departments. Pregnant adolescents are mentioned in the guidelines as a priority group among mothers at high nutritional risk.

The WIC Program is authorized to provide cash grants to state health departments for supplemental food items such as milk, cheese, eggs, juice and cereal for mothers and children and formula, cereal and juice for infants. Payments are made by the state health departments to local clinics which in turn distribute the food directly or in the form of vouchers. The Agriculture Department's Food and Nutrition Service is still accepting applications from state health departments, according to Ms. Nancy Weik, who is in charge of the program nationally. She advises that clinics in "the most needy areas" will be funded first and emphasizes that it is "very important for areas applying to tell us everything they know about the population to be served."

The Children's Foundation is offering technical assistance to those interested in preparing applications. If you need further help call Billie Ann Stultz at The Children's Foundation (202) 296-4451. You should act as soon as possible. To expedite the application submitted by your local clinic, call your state health department and let them know the application is on its way.

Shirley A. Nelson
Director

Cincinnati's Decade of Progress... Helping School-Age Parents

A decade has made a significant difference in the type of services available to school-age pregnant girls in Cincinnati. In 1963 adolescents received no special consideration for the unique problems they face during and after pregnancy. Only the regular services open to adult women in the community were available. Yet large numbers of young girls were pregnant and experienced a high incidence of obstetric complications, prematurity and repeat pregnancy.

The situation in Cincinnati in 1973 is far different. Special education, health and social services are now readily available to adolescents. As a result, there has been a definite improvement in the school and job success of the young women who have received these specialized services, and a definite downward curve in repeat pregnancies.

It is hoped that this examination of what has happened in Cincinnati over the last decade may prove useful to other communities.

By Joseph L. Rauh, M.D., Director, and Lois B. Johnson, M.D., Associate Director, Adolescent Clinic, Cincinnati General Hospital

THE CITY AND ITS BACKGROUND

Located on the Ohio River, Cincinnati is an old midwestern city of half a million people. The total population has not changed significantly for several decades, although the black population has slowly increased to 25% of the general population and 45% of the public school population. Cincinnati has always had a sizable number of families of German descent and its traditional Catholic population has exercised considerable influence as well. Besides blacks, a white Appalachian group migrates to and from the Kentucky-West Virginia-Tennessee area and is an important minority influence. Hamilton County, of which Cincinnati is the largest municipality, has a population of just over a million.

The Cincinnati school district has never kept accurate and complete information on pregnancy. A decade ago most pregnant girls left school and did not return. Often the school did not know why they withdrew. With the advent of special schools for pregnant girls and somewhat better record-keeping, it is estimated that approximately 450 girls became pregnant during the last complete school year, 1971-72. (The total public school district enrollment is about 80,000.) However, of the 450 girls who became pregnant, only 300 were permitted or chose to attend special schools.

SPECIAL SCHOOLS

In 1964 the Cincinnati Board of Education established a special school for pregnant teenagers in the Catherine Booth Maternity Home. The initial impetus for this school was the education needs of the young women in residence, most of whom came from a largely white, middle-class population in the area. In 1966 federal funds became available to the Board of Education through the Elementary and Secondary Education Act (ESEA-Title I). By early 1968, the Catherine Booth School was admitting girls who transferred from local public high schools. Most of these girls were black and from low-income families. A second special school was established in the downtown area in early 1968 and later moved to another old suburb in the city, McMillan Center.

The Catherine Booth school and the McMillan Center school are less than two miles from the Cincinnati Health Department and its numerous clinics which are largely funded by the federal Maternity and Infant Care Project. Also nearby is Cincinnati General Hospital where 90% of the girls deliver. Each of the schools is staffed by three or four certified teachers as well as a secretary. In order to be eligible for admission a girl must be referred by her local high school counselor and must be receiving prenatal care. Each of the schools is staffed to handle a maximum of 60 girls, although the enrollment this year (1972-73) has dropped to an average of 35-40 girls per school. The curriculum has emphasized basic subjects such as English, mathematics, science, etc. The major objective is to help the girl continue her education so that she does not fall behind in her regular high school classes and is able to return to school after delivery.

Only those girls who reside in areas of Cincinnati eligible for federal funding may attend these special schools. It is estimated that 70% of the public school population lives in such areas. Formerly, pregnant girls living in non-ESEA areas could receive home instruction if they made arrangements for it. More recently, many of these girls are staying in their regular high schools. While this development is encouraging in terms of the general well-being of the pregnant adolescent, it ignores their need for concentrated health education and related social services.

HEALTH CURRICULUM

In 1969 a number of community agencies serving these special schools became concerned about the low priority given education in the areas of health and sexuality. Since no one from the Cincinnati public schools was trained or prepared to teach in these areas,

the agencies decided to join together to assist the special schools with their health education. The agencies included the Adolescent Clinic of the Cincinnati General Hospital, the Cincinnati Health Department, Maternity and Infant Care Project #545 (part of the Health Department), the Obstetrics and Gynecology Department of the University of Cincinnati Medical Center at General Hospital, the Salvation Army (which administers the Catherine Booth Maternity Home), Planned Parenthood Association, and the Hamilton County Welfare Department.

Each agency made a commitment of staff to teach health and sex education during the regular school day. Through a series of meetings involving this "extra" health faculty and regular school staff, a nine-week curriculum was designed (see Table I). The series is repeated four times during the regular school year. In this way, any girl who stays in special school at least nine weeks receives the entire course. Most girls begin special school during their fourth or fifth month of pregnancy and stay through delivery and the immediate postpartum period. This year the health curriculum was established as a regular credit course at the high school level. It consists of 20 hours of instruction (about two hours per week) for nine weeks. Grading is related to attendance: a girl who attends 90% of the hours receives an A; for 80% she receives a B; etc. No one fails but absences must be made up prior to delivery.

The health curriculum has been well received not only by students but by the Board of Education, and the administration and regular faculty of the special schools. This positive reception has been due in large part to the careful background work accomplished in the regular faculty meetings. These meetings permit all faculty members to review the program periodically, present new ideas, and discuss mutual problems; this is often the only time the entire staff of both schools compare notes and get to know each other. Without them the health curriculum could not be maintained.

RETROSPECTIVE FOLLOW-UP

The health faculty is currently gathering information on obstetric and infant outcome as well as on birth control methods and the girls' educational experience after delivery. Much of this data gathering process requires hospital chart review, telephoning and personal contact. Some of this information is presented in Table II along with data already published on adolescents seen almost a decade ago at Cincinnati General Hospital. The table compares four groups of adolescent girls who delivered at Cincinnati General Hospital at varying time periods from 1964 to 1971. The groups are all composed of girls 13 through 18 years of age and of lower socio-economic background. The mean age for each group is 16, and most girls are unmarried. However, there is considerable variation in their racial composition, clinic experience, time of delivery, opportunity for contraceptive services and school experience.

The primary reason for comparing this data is to illustrate the trend in the incidence of repeat pregnancy during the past decade in Cincinnati. The results reveal that after two years 70% of the original General Hospital Group A surveyed from 1964-65 had had at least one repeat pregnancy. This percentage is identical to the finding of a five-year follow-up study of a similar urban population in New Haven, Conn. in the early 1960's.

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TABLE I: HEALTH AND SEX EDUCATION CURRICULUM AT SCHOOLS FOR PREGNANT ADOLESCENTS IN CINCINNATI

WEEK	SUBJECT	INSTRUCTOR
1	Introduction to human sexuality, human reproduction, review of contraceptive methods, discussion of social and emotional implications of early pregnancy, sharing of feelings of self-esteem, attitudes toward boy friend, parents, siblings, ideas for the future	Sex educators from Planned Parenthood Association, and College of Education, University of Cincinnati
2	Continuation of Week #1	Same as Week #1
3	Continuation of Week #1	Same as Week #1
4	Nutrition during pregnancy, complete review of normal weight gain, fetal growth, food needs, major obstetrical problems related to excessive salt or caloric intake, food selection, value of vitamin and mineral supplements	Nutritionist from Maternity and Infant Care Project, Cincinnati Health Department
5	Value of the prenatal medical visit, what is done there and why, discussion of major obstetric complications	Obstetrician from prenatal clinic, Maternity and Infant Care Project
6	Discussion of obstetric anesthesia, labor, delivery and immediate postpartum period and field visit to labor and delivery area of Cincinnati General Hospital	Labor-delivery room registered nurse Cincinnati General Hospital
7	Child care, breastfeeding, preparation of formula, infant diet, techniques and need for infant stimulation	Health professional, Cincinnati Health Department
8	Home management, budgeting money for infant needs, good money management	Health professional, Cincinnati Health Department
9	Summary session, review of curriculum, further discussion about the relative merits of contraceptive methods, question-answer periods about other medical problems such as venereal disease, etc.	Pediatrician from Adolescent Clinic, General Hospital

The Cincinnati data further revealed a significant 30% drop in the repeat pregnancy rate when contraceptives were made available to adolescents postpartum, as seen with 89 Adolescent Clinic girls, Group B, who were studied during the mid and late 1960's. None of the girls in Groups A and B in Table II attended a special school for pregnant girls.

Groups C and D presented in Table II provide a more recent experience for comparison. All these girls were black, all delivered at Cincinnati General Hospital during a six-month period from October 1, 1970 through March 31, 1972. All the girls in Group D attended either Catherine Booth or McMillan Center for a minimum of four weeks before delivery; the great majority attended for three to six months. None of the girls in Group C attended a school for pregnant girls, and like the girls in Group D, most attended a Maternity and Infant Care Project prenatal clinic. After careful hospital chart review and some telephone follow-up, a repeat pregnancy rate of 35% was calculated for Group C. Group D was found to have a low 20% rate of repeat pregnancies. Although follow-up is still incomplete, the difference in these rates of repeat pregnancy is not expected to change significantly.

The follow-up of pregnancy outcome showed that nine girls from Group C and six from Group D had babies weighing less than 2500 grams. One of the babies born to a girl in Group D was stillborn, weighing 1780 grams, and one was an early spontaneous abortion (less than 1000 grams). All of the small infants from Group D weighed over 1500 grams. The mean weight of the babies in Groups C and D was almost identical, between 3000 and 3100 grams.

The study already has shown that most of the girls from Group D have returned to school compared with those in Group C. It is hoped that a further follow-up study of Groups C and D will reveal more about the girls' long-term contraceptive experience, marital status, and college or job experience.

CONCLUSION

These findings point up the significant influence of a special school experience on repeat pregnancy; moreover, there seems to be a greater influence in this area than on the actual outcome of pregnancy. Special schools for pregnant adolescents are only one component service in a total community program. Available, comprehensive prenatal care such as that offered by Maternity and Infant Care Projects and family planning clinics for teenagers are obviously essential, too. However, it should be emphasized that the school program is vital, especially as it positively influences repeat pregnancy and school and job success. The Cincinnati experience with adolescent pregnancy during the past decade strongly suggests that multiple health and social service agencies should continue to provide health and sex education in special schools for pregnant adolescents.

TABLE II: COMPARISON OF REPEAT PREGNANCY AMONG FOUR GROUPS OF PREGNANT ADOLESCENTS RETROSPECTIVELY FOLLOWED FOR TWO YEARS DURING THE PAST DECADE.

GROUP	NO.	MEAN AGE	PERIOD OF DELIVERY	DISTINGUISHING CHARACTERISTICS	PERCENT PREGNANT AGAIN
A	83	16	1964-1965	70% black, attended prenatal clinic, no contraceptive or school services, high incidence of obstetric complications and prematurity	70%
B	89	16	1965-1968	90% black, all came to Adolescent Clinic prenatally or immediately post-partum. All offered contraception within adolescent medical program, low incidence of obstetric complications and prematurity	30%
C	80	16	1970-1971	100% black, attended adult Maternity and Infant Care clinics, did not attend special schools during pregnancy, moderately low incidence of obstetric complications and prematurity	35%
D	80	16	1970-1971	100% black, attended special schools during pregnancy for at least four weeks, used Maternity and Infant Care clinics, almost identical to Group C for obstetric complications and prematurity	20%

Preventing Repeat Pregnancy:

Teen Clinic Shows Promising Results

Another example of a low-rate of repeat pregnancy achieved through special medical services and counseling sessions is reported by Dr. Peggy B. Smith, Director of the Joyce Goldfarb Adult Development Clinic, Baylor College of Medicine, Houston, Texas.

Of the 267 girls who have participated in the clinic's experimental antepartum program, only 13 percent have had subsequent pregnancies. "While not enough time has elapsed for conclusive results, initial investigations indicate that contraceptive methods are accepted and used over a short time by participating adolescents," Dr. Smith notes.

Funded by the Rockefeller Foundation and now in its fifth year of operation, the adolescent services of the clinic are an integral part of the obstetrical services at Jefferson Davis Hospital. The program provides comprehensive perinatal, psychosocial services to pregnant teenagers from low-income families. For the antepartum sessions, teenagers are chosen at random from the obstetrical clinic to attend weekly three-hour seminars with discussions centering on marriage, dating, sex education, proper nutrition for mother and infant, labor preparation, and personal hygiene.

An obstetrician, a midwife, a nutritionist, a registered nurse, and a pediatrician form an interdisciplinary team which emphasizes the use of terminology within the linguistic and cultural experience of each girl. The approximate racial composition of the teenage population involved is 80 percent black, 10 percent Caucasian, and 10 percent Latin American.

Games are often used to increase the girls' interest. To motivate the girls toward sensible eating habits, a food vocabulary is used in crossword puzzles and bingo.

In contrast to the random selection of antepartum patients, all post-delivery teenagers without major medical complications are returned to a special ward. Because of time limitations, usually a three-day hospital stay, the postpartum sessions are intensive. They stress the importance of preventing rapid, repeat pregnancies with detailed explanation of contraceptive methods.

As soon as the patient is ambulatory, she begins the series of classes. Each series consists of six sessions lasting approximately an hour twice a day. These ward meetings are sandwiched between routine care and provide the adolescent an opportunity to clarify and correct previously obtained information related to anatomy, conception, birth, contraception, dating and premarital sexual experience. Multimedia presentations illustrate information on child care.

While group counseling and interactions are integral to the delivery of the postpartum service, provisions are made for individual needs. A registered nurse is on 24-hour call to answer telephone questions and counsel former teenage patients in the various aspects of birth control and contraception. This is especially important with the use of birth control pills, for even though girls attempt to follow instructions, errors may result in pregnancy.

The Adult Development Clinic reports favorable results from the postpartum phase of the program. In the last five years 5,270 teenagers have participated. More importantly, after discharge, 75 percent of the participating adolescents accepted a medically approved method of birth control. Moreover, the same percentage returned for the first routine postpartum checkup.

State Conferences: Discussing the Issues and Planning for Action

One of the primary goals of the Consortium's conference strategy is to arouse statewide interest in the establishment of comprehensive services to school-age parents and their infants. As part of this effort the Consortium has sponsored 12 statewide conferences in cooperation with state agencies. Planning for a series of Fall conferences is now underway.

By bringing together leaders in the fields of education, health, and social services the conferences provide an information sharing opportunity and a forum for the discussion of action plans at both the state and local levels. The following summaries of Consortium-sponsored conferences in the late Spring of this year describe the issues discussed, the concerns expressed, and the types of action plans formulated.

KANSAS

The Kansas State Conference on School-Age Parents held April 18 at Kansas State University attracted over 228 participants from 39 of the state's 105 counties. The idea for a statewide conference grew out of a two-part institute on the special needs of school-age parents cosponsored in 1972 by the Kansas Department of Education in cooperation with Kansas University. During and after the institute, Clifford Curl, Director of Special Education for the Kansas State Department of Education, and Jeanne Arradondo, Conference Coordinator on the Consortium staff, discussed the feasibility of a state conference on school-age parents. Interest in such a conference was also expressed by Dr. Evelyn Gendel, Director of the Division of Maternal and Child Health, Kansas State Department of Health.

Since both departments are members of the Kansas School Health Advisory Council, it was agreed to request the Council to focus on the subject of school-age parents at its annual Spring meeting. The Council is a multidisciplinary organization consisting of 40 private and public volunteer and professional agencies. Other Council members include the Kansas Medical Society, Kansas State Dental Health Association, Kansas Congress of Parents and Teachers Association, Kansas National Education Association, Kansas State Nurses' Association, Kansas Association of Health, Physical Education and Recreation, Kansas Public Health Association, Kansas State High School Activities Association, Kansas Association of Secondary School Principals, Kansas School Nurse Organization, Kansas Auxiliary to the Optometric Association,

Kansas Lung Association, Kansas Association of School Administrators, Community School Health Project, and the Kansas University Medical Center.

Over 300 invitations to the conference were mailed to professionals in the fields of health, education and social services. Participants included secondary school superintendents and principals, counselors, teachers, students, health personnel and regional staff members of the U.S. Department of Health, Education, and Welfare.

Keynote speaker for the conference was Marion Howard, Boston, Mass., former director and now consultant to the Consortium on Early Childbearing and Childrearing, who spoke on "School-Age Parents, Issues and Answers." The afternoon session was devoted to a series of small group discussions covering such topics as public school policies on teenage parents; infant care and child development; counseling and preventive services, and education for sexuality.

At a follow-up meeting on May 31, attending officers and members of the Kansas School Health Advisory Council supported a recommendation to hold another conference in the near future which would emphasize topics such as day care and young fathers, that participants felt should be given more attention. Council members noted that immediately following the April 18 conference the subject of school-age parents was receiving more attention and was beginning to appear on the agenda of many professional training meetings.

The Council voted to create an ongoing task force to examine issues and needs of school-age parents, and coordinate statewide strategies and policies. In addition to Council membership, the task force would also represent a variety of state and community interests. It was suggested that future functions of the task force, with its broadened representation, might include: assessing the extent of the problem, identifying service needs and resources; developing an action plan, overseeing and coordinating the service delivery, and evaluating the results.

OKLAHOMA

Over 325 participants attended the Oklahoma State Conference, "Focus on School-Age Parents" held April 27-28 in Central High School, Tulsa, Oklahoma. Sponsors included the office of the Governor, and the State Departments of Institutions, Social and Rehabilitative Services, Health, Education, Mental Health, and the Department of Gynecology and Obstetrics, College of Medicine, University of Oklahoma Health Sciences Center in cooperation with the Margaret Hudson Program for School-Age Parents and the Consortium.

Twenty-five of Oklahoma's 77 counties were represented by participants from a variety of agencies including the Oklahoma State Human Rights Commission, Oklahoma City-County Criminal Justice Council, Fort Sill Military Base, county health departments, schools, hospitals, nursing schools, and the Oklahoma City Indian Health Service. District VII of the American College of Obstetricians and Gynecologists provided conference reception facilities and encouraged attendance by its members who were convening simultaneously in Tulsa for a state medical meeting. Mrs. Lois Gatchell, Director of the Margaret Hudson program (Tulsa), served on the conference planning committee and received the support of Oklahoma Governor David Hall in calling a special March 1 meeting of state agency officials and others to discuss the needs of school-age parents. Jeanne Arradondo served as Consortium coordinator of this meeting in the State Capitol in Oklahoma City, which resulted in an agreement by the officials to hold a statewide conference.

Keynote speaker for the conference was George I. Lythcott, M.D., Associate Dean for Urban and Community Health Affairs,

Professor of Pediatrics, College of Physicians and Surgeons, Columbia University. Other speakers were Joseph McKnight, professor of law at Southern Methodist University and Director of the Family Law Project of the Texas Bar Association, who spoke on the "Legal Aspects of Early Childbearing" and W. Stanley Kruger, Director of the Inter-Agency Task Force on Comprehensive Programs for School-Age Parents, in the Office of Education, U.S. Department of Health, Education, and Welfare, who spoke on the "Educational Needs of School-Age Parents." Audrey McMaster, M.D., Associate Professor, Department of Gynecology and Obstetrics, University of Oklahoma Health Sciences Center, provided the conference summary and evaluation.

A panel of young mothers from the Margaret Hudson Program, Tulsa, spoke of the problems of school-age parents from their point of view. A series of small discussion sessions featured such topics as designing and funding a comprehensive program, infant care and child development, counseling for school-age parents, the special needs of young fathers, prevention of adolescent pregnancy, and the special health needs of the adolescent mother.

In order to maintain the momentum generated by the conference, members of the Margaret Hudson Program at a board meeting June 12 initiated follow-up plans by drafting a resolution on comprehensive services to school-age parents. Eve Marvin, President of the Margaret Hudson Board of Directors, wrote to Governor Hall enclosing the resolution and asking him to convene a follow-up planning meeting. The resolution contained the following recommendations:

- That a task force comprised of representatives from the Department of Institutions, Social and Rehabilitative Services, the Department of Education, the Department of Health, the Department of Mental Health, University of Oklahoma Health Sciences Center, Oklahoma Council on Juvenile Delinquency, and other interested persons be appointed to consider ways of providing coordinated and comprehensive services for school-age parents and infants using services available from the above departments and to study the feasibility of establishing regional programs throughout the state similar to the Margaret Hudson Program in Tulsa.

- That the task force consider calling a conference to study innovations in the public school curriculum which would adequately equip the teenager to cope with the psychological and physiological problems created by adolescence which can eventually lead to teenage pregnancies

- That the task force plan appropriate legislative changes to implement the organization and funding of the comprehensive service concept.

Letters were also sent to all conference participants asking them to write to Governor Hall urging such a meeting and also asking them to invite a concerned group to study the needs of school-age parents in their individual communities and draft action plans.

MISSISSIPPI

A statewide conference on school-age parents was held April 27 at the Medical Center Holiday Inn in Jackson, Miss. Sponsored by the Mississippi Council for Voluntary Family Planning, the Mississippi State Board of Health, the University of Mississippi Medical Center, and the Consortium, the conference drew 300 participants from the fields of health, education, and social services as well as students, community leaders and agency representatives.

A Task Force on School-Age Pregnancy organized by the Mississippi Council for Voluntary Family Planning was instrumental in planning for the conference. In order to determine the

extent of the school-age pregnancy problem, the task force sent a questionnaire to all the public school superintendents and private school principals in the state. Responses from 38% of those surveyed showed that approximately 983 students had become pregnant during the 1971-72 school year. Grades 10 through 12 represented 71% of the pregnancies. In addition, the Mississippi State Department of Education identified 3 fourth graders, 9 fifth graders, and 21 sixth graders who left school because of pregnancy during the 1971-72 school year.

The questionnaires also revealed that almost half of the responding districts did not allow pregnant girls to remain in school after the pregnancy was discovered. Twelve percent of the respondents stated that young mothers were not allowed to return to school at all. Further, the responses showed that few of the districts or schools have any kind of family life or sex education courses at any level.

Keynote speaker for the conference was Marion Howard. A panel discussion on state and community resources was moderated by Nancy Gilbert, Executive Director of Operation Shoestring in Jackson, Miss. The afternoon program consisted of workshop sessions on counseling, legal issues, infant care, family life education, and programming.

The participants in these sessions came up with several recommendations. In the area of education it was proposed that family life courses be offered throughout the state in public and private schools from kindergarten through twelfth grade. It was pointed out that the introduction of such courses would present no legal conflict but would require community as well as parental support. It was also noted that continuing education for school-age parents helps to reduce economic disability and increases the likelihood of breaking out of the cycle of poverty. The Mississippi Legal Code does not have a stated policy on continuing education for school-age parents; however, the U.S. District Court has ruled that school-age parents can remain in the public education system except under extreme circumstances.

The participants also recommended that social and health services be made readily available to school-age parents, with increased hospital and welfare benefits, especially in the area of family planning.

NEW JERSEY

Over 316 persons attended the New Jersey State Conference on the Special Needs of School-Age Parents sponsored by the New Jersey State Departments of Education and Health and the Consortium on May 8 at the Holiday Inn, New Brunswick, N.J. Representing 19 of the state's 21 counties, 33% of the participants were from the field of education, 31% from welfare, 24% from social services, and 7% from child development. The remaining 5% represented professionals from law, the clergy, or young parents.

Impetus for the New Jersey conference was given by Grace Berg, Director of Midwifery at the Margaret Hague Maternity Hospital in Jersey City, who contacted the Consortium and asked for help for young mothers who were being forced to drop out of school and were being denied services. Roberta Chabalko, a Conference Coordinator on the Consortium staff, contacted Carl L. Marburger, former New Jersey Commissioner of Education, an active supporter of programs for school-age pregnant girls. He suggested Dr. William A. Shine, Assistant Commissioner for Curriculum and Instruction, who agreed to serve on the planning committee for a conference. The State Department of Health agreed to cosponsor the conference and appointed Bernard N. Millner, M.D., Director of Parental and Child Health Services, to develop planning and follow-through. Frederick Schenck,

Director of Youth and Family Services in the State Department of Institutions and Agencies, was appointed by that agency to serve on the conference planning committee.

Bernard Braen, Ph.D., Acting Director of the National Alliance Concerned with School-Age Parents, was the keynote speaker for the conference. A Parents' and Professionals' Panel was moderated by Marilyn Miller, Fiscal and Social Counselor of the Model Cities' prenatal clinic in Jersey City.

During lunch, coordinators for the four state comprehensive health planning regions met to plan follow-through action in individual counties.

The afternoon was devoted to a series of small group discussions. The session on counseling young parents and grandparents attracted the most participants. A session on medical services discussed health care delivery including prevention. The various facets of good family planning programs were discussed, with emphasis on the special needs of teenagers. It was stressed that the availability of birth control does not provide a solution to prevention of adolescent pregnancy; a need for improved family life education was also emphasized.

In separate sessions on education for parenthood, infant care and child development, and regular vs. special classes, participants examined the education component of a comprehensive service program. The State Department of Education through its department of home economics, is in the process of working with local school districts to develop programs which meet the needs of young parents. A small group discussion on funding examined possible funding sources and the structure of state agencies, and the implications revenue sharing may have for local programs.

Follow-through activities in New Jersey are focusing on the involvement of the four Health Planning Council regions in the state, coordinated by regional chairmen. Within each region, county organizations are being formed in order to develop coordination of services on a local level. In addition, the conference advisory planning committee voted to become a statewide organization--Regional Advisory Planners-Teenage Parenthood (RAP-TAP), which will meet semiannually to decide on issues that could benefit from statewide involvement. At the next meeting they will discuss an affiliation with the National Alliance Concerned with School-Age Parents through the formation of a New Jersey chapter.

CONFERENCE QUOTES

A number of outstanding speakers discussed the issues relating to school-age pregnancy and offered some solutions to the problems confronting school-age parents. The following summaries contain some of the significant points made in their speeches.

Marion Howard, former Director and now Consultant to the Consortium on Early Childbearing and Childrearing, Boston, Massachusetts

With an unprecedented 75% of young people graduating from high school--almost double the proportion graduating in 1940--it is apparent that a person without such an education is at a distinct disadvantage in our society according to Ms. Howard.

Speaking at both the Kansas and Mississippi conferences, she stressed that education is a basic need of every individual, particularly today. "For girls who become pregnant while still of school-age, education is of genuine importance. It is crucial not only for their

role as parents but for their role as self-sustaining, contributing citizens."

Studies have shown that lack of education is associated with underemployment, unemployment, and welfare dependency, Ms. Howard pointed out. In order to help young parents reach educational goals, support and encouragement must start during pregnancy. This means continuation of regular education, necessary remedial work, and special education related to pregnancy, preparation for childbirth and parenthood. Pregnant girls often drop out of school permanently if continuing education is not available to them. On the other hand, if the pregnancy period is used to increase motivation to continue in school, the result may be that girls benefit more from education and actually achieve higher grades than they did before their pregnancy.

Whether the girls are allowed to remain in regular school classes or are given their education in special classes will depend on the needs of the girls and the resources of the community, Ms. Howard noted. However, she pointed out, the responsibility for providing such education rests squarely with those institutions that ordinarily would be providing education for the girl if she were not pregnant. The pregnancy in no way exempts them from their responsibility.

"Societal and individual goals, however, go beyond the provision of education and the attainment of a high school diploma," Ms. Howard declared. "They relate to healthy mothers and infants, to stability of family life, to mature, productive citizens. Thus, the health and counseling needs of young parents and parents-to-be must be met along with their educational needs.

"Sound health services must be provided for pregnant girls. The risk of complications during pregnancy and the danger of handicapping conditions such as mental retardation in the infant increase inversely with the age of the girl; the younger the girl, the greater the risk. It is important, therefore, that school-age mothers enter care early and receive consistent quality care throughout pregnancy and in the postpartum period. Pediatric and follow-through nursing services also should be made available. Moreover, to be effective, health services for young mothers need to be delivered in age-appropriate ways."

Ms. Howard also emphasized the need for counseling to help the girls and young fathers arrive at solutions to problems relating to abortion, adoption, marriage, single parenthood, personal and family relations, and educational and vocational choices. "The establishment of a continuing relationship built on concern and mutual trust is one of the most important aspects of counseling pregnant girls and young parents," Ms. Howard declared. "Adolescents who view adults with distrust and suspicion and often have not had positive relationships with adults before require sensitive and nonjudgmental adults as counselors."

Education and services geared to pregnancy prevention are other primary responsibilities of those serving adolescents, Ms. Howard stressed. This aspect of service should not be neglected for either young parents or sexually active adolescents in the community, she added.

"As concerned professionals and lay people we must rid ourselves of false illusions about sexuality in adolescence and offer meaningful services to young people experiencing growth as physical beings. In the case of pregnant girls and young parents, the breaking down of services in each community can go a long way toward meeting the needs of this population. How much better to work with young people while there is so much room for growth and change than to later face costly remedial programs or welfare support for either the young parents or their children," Ms. Howard concluded.

George I. Lythcott, M.D., Associate Dean for Urban and Community Health Affairs, Professor of Pediatrics, College of Physicians and Surgeons, Columbia University, New York City

Unplanned, unwanted, premature parenthood need not exist, except uncommonly, in an environment where comprehensive programs are available, Dr. Lythcott told participants at the Oklahoma conference.

He advocated making such programs readily accessible to all teenagers regardless of their age, sex, or marital status. "These programs should not be restricted to those who have already provided proof of their sexual activity by conceiving, or contracting venereal disease, or by getting married early," Dr. Lythcott declared. "Surely, we as mature adults cannot subscribe to the belief that telling young people about sex and birth control before they have experienced coitus is tantamount to encouraging them to rush right out of our offices to employ the newfound knowledge. Chances are teenagers have been aware of sexuality and privy to considerable information--some accurate and unfortunately, some fallacious--long before we became courageous enough to approach them about it."

Discussions on prevention of school-age pregnancy should not be limited to females, Dr. Lythcott noted. "After all, it takes two to tango, and males as partners in the reproductive cycle have the same rights to salient discussions. One need only hear teenagers reiterate, 'I thought it wouldn't happen to me,' or 'I never even thought about it,' to realize how sexually unsophisticated are our sexually active youth." He continued: "We should bear in mind that while many of these young parents or parents-to-be exude an aura of independence, defiance, self-assurance, etc., they are more often than not desperately trying to conceal their extreme vulnerability and unmet dependency needs which result from their limited and frequently deprived life experiences. We owe it to these youngsters to provide them with accessible, accurate information. It is the first and fundamental step to take if we really are concerned. Family life services programs, not just sex education, could be such a valuable adjunct to any young person's learning experience."

In his work in various communities around the world Dr. Lythcott said he has observed many people who have designed excellent medical and social service programs for a particular population "only to see that program fail because the staff delivering the services have not effectively come to grips with their own prejudices toward the population they are supposed to be supporting." He added, "I therefore cannot emphasize enough the importance of examining one's own feelings about sexually active youth before one purports to help them."

In addition to preventing premature parenthood by providing young people with adequate sex education and information about contraceptive techniques, Dr. Lythcott advised that the teenagers' own families should provide a place for them to work out their frustrated emotional needs before they become pregnant.

"Somehow," he said, "parents must reestablish caring dialogue with their children from the early years rather than suddenly trying to lecture their teenagers out of fear alone. It is true that many of us, as parents, are prisoners of our own backgrounds and experiences. It is very difficult to talk about sexuality with our children, particularly for those of us who grew up in an environment where the subject was taboo. It is surely, however, part of our responsibility as parents in a culture saturated with sexual material of all kinds to help our children. It is also encumbent upon us to constantly remind ourselves that their exposure and orientation as teenagers is vastly different than ours was."

Young people today are "begging for guidance," Dr. Lythcott declared, but it should be guidance

"that includes respect for their differing world and circumstances." He noted that older people expect openness and honesty from adolescents but often are not willing to "listen more and lecture less."

In discussing the prevention of unwanted pregnancy, Dr. Lythcott recognized the controversial nature of abortion. "Abortion is an emotionally charged issue about which innumerable papers both pro and con have been written," he stated. "Countless hours of arguing have been spent in a variety of forums and heated discussions have taken place in every possible arena where people meet. Regardless of one's personal ideology, however, the Supreme Court of the United States has firmly established, as the law of the land, the woman's unconditional right during the first trimester of her pregnancy, regardless of her age, marital status or any other variable, to decide whether or not she wants to carry her pregnancy to term. Abortion, therefore, has been legally added to the list of methods to prevent unwanted parenthood."

Despite the availability of contraceptive knowledge, however, there will continue to be some young women who will carry through their pregnancies, Dr. Lythcott observed. These young women, he noted, should be given all the "external supports" a community can provide. They should be allowed to continue their education so that they do not find themselves at some future date permanent residents on the welfare rolls.

Another source of support, Dr. Lythcott suggested, would be an increased community commitment to the development of child care and infant stimulation centers. "The concept of infant stimulation centers as opposed to passive baby sitting operations offer parents the opportunity to receive guidance, instruction, and counseling in parenting. Such centers teach the understanding of infants, of their needs and behavior, which is a discipline not frequently offered to new parents."

Postnatal residences are another service the community might provide, he added. "How often have we heard social workers lament about the paucity of housing resources for a teenage girl and her baby. Plans must often be made to separate a young mother and her baby in different foster homes when the primary home from which the girl came is ill-suited for her to return. This concept of postnatal resource residences, child-care and other services for the teenage parent could be an invaluable aid in reducing repeat, rapid pregnancies and their resultant difficulties."

The combination problem of teenage drug use and teenage pregnancy also must be recognized, Dr. Lythcott stressed. "Our young people in the ghettos as well as the suburbs are increasingly involved in popping pills, smoking pot, and even, heroin and an ever-increasing number are becoming addicted to the latter." He noted that the "young female addict may become pregnant and deliver a child tremulous with withdrawal symptoms a few hours after birth." Another problem among addicted premature parents, Dr. Lythcott stated, is "an extremely high incidence of child abuse and neglect of their young, plus the tendency to shunt the infant onto friends or relatives."

In conclusion, Dr. Lythcott advised the participants: "It is our responsibility as professionals and concerned citizens to organize and develop rational approaches including preventive and supporting programs that will address themselves to the complex issues of teenage pregnancy. It is further incumbent upon us, in my judgment, to carry these ideas and convictions to their logical conclusion--to influence and win the support of those individuals, agencies or institutions in the local and state setting within whose jurisdiction direct or indirect responsibility for implementing such activity is vested."

Bernard B. Braen, Ph.D., Executive Director of the National Alliance Concerned with School-Age Parents (NACSAP), Syracuse, N.Y.

"I have found it difficult to confirm many stereotypes that have been expressed regarding the pregnant teenager," particularly that she is "dull, poor, black, pleasure-seeking and psychologically or culturally deprived," declared Dr. Braen, keynote speaker at the New Jersey conference.

He added, "This stereotype suggests that any bright, rich, white girl who keeps her nose to the grindstone and comes from a psychologically intact family, will be unlikely to have intercourse under the age of 18, and certainly would not become pregnant. I suppose this is why any girl who fits the latter description always seems to have nine-month mononucleosis as the official reason for her departure from school. In other words, there is a tendency in this country to think of teenage pregnancy as indigenous to the black culture. Yet it is of interest to note that 60% of the school-age pregnant girl population in this country is white."

Dr. Braen, one of the founders of the Y-MED program in Syracuse, N.Y., observed that the problem of school-age pregnancy is not one of ethnicity, financial status, geography, or class level, but relates to the whole society. "The message I get from working with these students is that they need and want relevant information, health care, counseling services, and continuing education. In other words, the services everybody else gets."

He warned, "If we condemn this group for remaining out of the mainstream of life, and do nothing to help them get in and stay in, then we are engaging in the purest form of self-fulfilling prophecy."

Another possibility for self-fulfilling prophecy, according to Dr. Braen, is the expectation that the teenager will fail as a parent. Many adolescents do fail as parents, he admitted, but he explained, "such failure is not necessarily because of their own inadequacies. Because people fail, it doesn't mean they haven't the capacity to make it. If those in the social environment are convinced the outcome will be dreadful, and the environment is set up to make it so, this conviction will help to make the prophecy of failure come true."

Little is currently known about adolescent parenting. Dr. Braen noted, and this has led the U.S. Department of Health, Education, and Welfare to establish an Education for Parenthood program jointly sponsored by the Office of Education and the Office of Child Development. The plan calls for the establishment of parenting education programs in 500 local school districts by September, 1973. These programs will seek to improve parenting competence among teenage boys and girls by increasing their awareness of child growth and development, the social, emotional and health needs of children, and the role of parents in fostering the child's development.

Dr. Braen cautioned those delivering services to take into account the very real differences between the 12-year-old and the 18-year-old pregnant girl. "We have a tendency to lump all school-age pregnant girls in one big category because they are pregnant and of school age. But all of us who work with these girls know that the social/psychological differences between those over and under 15 are immense. It is crucial that these differences are recognized and program development should take them into account."

Even though comprehensive services help substantially to reduce the risk of early childbearing, there are still problems, Dr. Braen declared. "One is follow-through...it has always seemed naive to me to assume that because a girl is provided quality educational,

health, and social services for six or seven months and there is positive change during this period, that such change will be sustained even though services are no longer available. Those of us in the business of behavior change know that it does not come about easily or quickly. Those of us who deliver service are too often aware of the girl who six months after leaving a program, is back to self destructive nutritional and health habits, and is essentially disenchanted with her life and herself."

The second area of concern, according to Dr. Braen, is primary prevention. "The problem here is in deciding what to prevent. We have to determine all the factors related to adolescent pregnancy before we talk about prevention. There are some who think of prevention as contraception and sex education. There are others who think of it as better employment opportunities, better recreation facilities, better housing; and there are others, particularly members of minority groups, who question whether there ought to be any conscious effort on the part of one group to prevent conception on the part of another. Here, of course, we are dealing with the genocide issue....It is clear that information and availability of service is not the total answer to primary prevention. The issue of motivation is central to this question."

In closing Dr. Braen emphasized that comprehensive services must be extended beyond the pregnancy and delivery. "They must be available to school-age parents and their infants for as long as they may be needed. Perhaps this sounds unrealistic from a fiscal, manpower, and community organization point of view...but anything less than this is tokenism."

Bernard N. Millner, M.D., Director, Parental and Child Health Services, New Jersey State Department of Health, Trenton, New Jersey

Speaking at the New Jersey conference, Dr. Millner emphasized: "Teenagers are sexually active. They need desperately to have more information than they now obtain as part of public school education. This should include information about pregnancy and its prevention, including contraception and abortion."

He added, "Sexually active or not, pregnant or not, they need education and health services. Our society should ensure that those school-age girls who become pregnant get the best of both. If we do less, we not only punish the child who is unfortunate enough to conceive, but we also punish ourselves, by adding to the burden of social, physical, mental and emotional problems which are weighing down our society."

Dr. Millner cited the following statistics on school-age pregnancy in New Jersey: Teenagers gave birth to more than 14,000 of the 111,000 babies born in the state in 1971. In the last five years, 1,327 babies were delivered by mothers under 15. Although the number of annual births in New Jersey between 1965 and 1971 fell from 125,000 to 111,000, the number of births to mothers between the ages of 10 and 14 rose from 191 in 1965 to 314 in 1971, an increase of more than 50%.

Also significant, Dr. Millner pointed out, was the even sharper rise in the number of low-birth-weight infants born to younger mothers. In 1965, 17% of the children born to these young mothers weighed less than 5½ pounds; in 1971 the number of babies under normal weight born to young mothers had increased to 21%.

"These facts illustrate several points," Dr. Millner noted: "Sexual activity among teenagers--those below the ninth grade level--seems to be increasing very rapidly; and the quality of prenatal care obtained by these youngsters seems to have deteriorated rather than improved since 1965, if low-birth-weight infants measures this."

The damaging effects of this trend on society should be evident, Dr. Millner observed, since low-birth-weight babies are more likely than average-weight babies to grow up with learning disabilities and other handicaps. "A severely damaged premature baby who requires lifetime institutional care may cost $500,000 in public funds. A fraction of this amount will purchase essential services needed to prevent his disability."

In addition to health services, school-age parents need educational services, "and have every right to expect the support of public funds to obtain them," Dr. Millner said. He added, "If we believe that prevention is better than cure, we must recognize the need to strengthen health education in public schools of the state." This means effective courses in sex education, including specific information about contraception, Dr. Millner stated. He noted that the Family Planning unit of the New Jersey Department of Health is "ready and eager" to work with the Department of Education and local school boards towards this end. "If invited, we will provide health specialists to help teachers prepare and present material related to this subject," Dr. Millner offered.

However, he stressed, the Health Department's principal responsibility is in the provision of health services for pregnancy, delivery and the postpartum period. In this regard, he noted, that while adolescents are given high priority for such services, they represent only a small percentage of the state's total need for public programs of obstetrical care.

Since 1966, Dr. Millner pointed out, state funds have been available to local governments through the Health Aid Act. "This statute provides funds which may be used for a wide variety of health services, but little of it has gone into obstetrical care programs, presumably because the municipalities do not place so high a priority on this kind of activity as on such services as public health nursing, drug abuse control, the collection of vital statistics, the inspection of campgrounds and restaurants, insect and rodent control, and so on, which are included among the 50-odd health activities for which the State Health funds may be used. Little of this money is spent for prenatal care programs."

Dr. Millner emphasized the importance of bringing pressure to bear on municipal health departments to make the right choices. "If there is not enough money available for both rodent control and prenatal care, citizens must request more support for these activities from our local and state governments and we must be prepared to pay higher taxes to obtain them."

Another mechanism for obtaining additional funds for these services, Dr. Millner suggested, would be the New Jersey Medicaid program. He explained that under this program funds spent on health care cost the state only fifty cents on the dollar; the other fifty cents comes from the federal government. "At present most pregnant schoolgirls are denied the benefits of Medicaid during their pregnancies and deliveries, and become eligible only after the birth of a child. Restructuring eligibility procedures to give coverage to pregnant schoolgirls would allow them to obtain early and adequate obstetrical care at minimum cost to the state," Dr. Millner said.

program notes

CONNECTICUT, New London

New London's Young Parents Program began in September 1971 to provide infant day care, continuing education, health care and social services for school-age mothers and their infants. The program is administered by a steering committee composed of representatives from many community agencies and organizations such as the YWCA, the Visiting Nurses Association, the State Department of Health, the Board of Education and Child and Family Agency. The Board of Education pays the salaries of the program's five paraprofessional and part-time teachers. Additional funding is supplied by a three-year federal/state grant from the Connecticut State Department of Health, Maternal and Child Health Section. The YWCA administers these funds which pay for rent, medical supervision in the day care center, transportation, and the salary of the program's coordinator.

Operating in a former school building which provides classrooms, a lounge and an infant care room, the school is in session Monday through Thursday from 9:00 a.m. to 12:15 p.m. Fridays are left free for staff planning meetings and visits to the girls' homes. The program coordinator, a certified teacher, works closely with the paraprofessional and part-time staff, and tries to visit each girl at home on a regular basis. Transportation to and from school is provided in a minibus loaned to the program by the YWCA.

The Young Parents Program is open to all pregnant school-age girls in the school district; 26 girls were served in 1972-73. Most enroll during the fourth or fifth month of pregnancy. The length of enrollment varies; most girls complete the school year in the program but, if they wish, they may return to regular classes postpartum as soon as it is medically advisable. It is felt that the program's half-day schedule offers the young mothers greater flexibility and allows them more time to be with their babies. To encourage girls to stay in school after they leave the program, the school board is considering initiating a half-day program for young mothers within the regular schools.

Young Parents offers all academic subjects needed for high school graduation, including foreign languages, mathematics and some sciences. (If a student needs to complete a credit in an advanced science, special arrangements are made with a teacher in her home school.) Two days a week a certified business education teacher gives instruction in bookkeeping, accounting, typing, and clerical office procedures. Girls may elect various arts and crafts ranging from drawing and painting to rugmaking and furniture refinishing. A special, full-credit

course on infant care and child development is also offered on an elective basis. The one-semester course combines regular classroom instruction with films, guest speakers, field trips, and practical experience in the program's day care center. Course content ranges from the research findings of Swiss child development specialist, Jean Piaget, to constructive ways for parents to handle discipline and anger. Specific information about prenatal care, labor and delivery (including breathing and relaxing exercises), nutrition, shopping, budgeting and other consumer concerns is provided by a volunteer from the New London County Extension Service. The ten-week course includes a field trip to the labor and delivery rooms of a local hospital, and to a local grocery store. By applying their knowledge of comparative shopping, unit pricing, menu planning, etc., the girls gain confidence in their ability to budget money effectively and to provide adequately for themselves and their babies.

Social service counseling is provided by the program's coordinator during her regular visits to the girls' homes. Additional group and individual counseling and related social service assistance is provided by Catholic Charities and Child and Family Agency. The program's coordinator meets weekly with the chairman of the steering committee who represents Child and Family Agency to assess and review the changing social service needs of the girls. Volunteers from the State Employment Bureau offer vocational counseling and job placement assistance.

The need for good medical care is stressed repeatedly in all aspects of the program. Girls must have a doctor's verification of pregnancy before entering the program and they must be under a doctor's care throughout enrollment. The program's coordinator and a registered nurse volunteer follow-up on the medical progress of each girl through home visits and consultation with her physician. Medical supervision for the children in the day care center is provided by a public health nurse from the Visiting Nurses Association. A doctor is always on call for the center.

The day care facility is licensed to care for 12 children; a ratio of one caregiver for every four children is required under Connecticut licensing regulations. The center has a full-time staff of two (a head teacher and a paraprofessional assistant) with a third worker on call for days when there are more than eight children in attendance. Development charts which include the day-by-day observations of the caregivers are compiled on each child and reviewed with the young mothers each month. In addition, the girls are urged to visit the facility often and to request individual conferences with the caregivers whenever necessary.

FLORIDA, Fort Myers

The Lee County Exceptional Child Education Department began serving pregnant students in a special program in January, 1972. An expanded program called LAMP (Lee Adolescent Mothers Program) was developed and implemented in the fall of 1972. In cooperation with the Lee County Health Department, the program now offers comprehensive education, health and social services to all school-age pregnant girls regardless of age or grade level.

In 1972-73, LAMP had a total enrollment of 55 girls; there are usually 20 to 30 girls enrolled at any one time. Most girls enter the program approximately midway through pregnancy and continue in attendance at least until their six weeks postpartum checkup. Prior to enrollment, each girl is visited at home by the program coordinator; the girl's parents are urged to accompany her to the initial interview and orientation at the LAMP center. The coordinator continues to make home visits throughout the girl's enrollment.

Classes are held in the former Dunbar Elementary School where, in addition to classrooms, girls are provided with a rest area and a lounge. The lounge is equipped with cribs and other baby supplies so that girls may bring their babies to school when they are unable to make other day care arrangements. School is in session daily from 8:00 a.m. to 12:00 noon. Both breakfast and lunch are provided. The program has the use of a minibus owned by the Multi-County Deaf Program and furnishes transportation to all girls who need it.

The LAMP staff consists of the full-time coordinator/counselor, a full-time, certified teacher, and a part-time aide. (It is expected that the aide will work full-time next year.) The teachers serve as the liaison between the students and their former classroom teachers. Academic assignments are collected from the home school teachers, completed by the students with the assistance of the LAMP staff, and returned to the home school for grading. In this way, students can continue in the curriculum established by their home schools and still receive individual instruction and remedial work whenever necessary. For the 1973-74 school year, this plan has been tentatively revised; the LAMP teachers will continue to follow general course outlines provided by the home schools but they will make and grade assignments themselves. To provide general health information and instruction in practical skills such as temperature taking and weight control, a school nurse teaches a weekly health and hygiene course. Health information regarding pregnancy and prenatal care, labor and delivery, postpartum care, infant care, family planning, and other subjects of special importance to the girls, is provided by a nurse from the Lee County Health Department who visits the program once a week. (This service will be expanded to two days a week next year.) Course material is supplemented by field trips, films, and speakers from the community. The speakers' presentations are videotaped for use with future classes.

In addition to her teaching duties, the health department nurse also serves as a liaison between the program and the health department's prenatal clinic. She familiarizes the students with the services available to them and assists them in making and keeping clinic appointments. All girls must be under a doctor's care and any absences are followed-up carefully by the program coordinator or the nurse.

Social service counseling is also done by the program coordinator in consultation with the Lee County Mental Health Clinic. Her regular home visits facilitate individual counseling and give her a better opportunity to assess the girls' needs. In informal group counseling sessions, the girls learn how to use the available community resources and are able to discuss common problems by sharing their fears and feelings.

IOWA, Davenport

In September, 1971, the Davenport Community School District opened Green Acres School to serve the educational, social and health needs of pregnant high school girls. The program was expanded in the spring of 1973 to include seventh and eighth grade students. Though the program receives its operating funds from the school district, services and support are contributed by many other community agencies and organizations such as the Scott County Mental Health Center, the Visiting Nurses Association, and Iowa Family and Children's Services. Girls who live outside the school district may attend Green Acres on a tuition basis. The total enrollment last year was 99. Girls are urged to enter the program as soon as they know they are pregnant, however, the actual time of enrollment varies from girl to girl. Students return to their home schools at the beginning of the semester following delivery.

Green Acres is located in a former elementary school building which has been remodeled to provide office and storage space, a large, multipurpose classroom with movable dividers, a counselor's office, and a consumer education room with four kitchen units. Classes are held daily from 10:00 a.m. to 4:00 p.m. The ten o'clock starting time was chosen to accommodate girls who might have morning sickness. Transportation is provided by the school.

Green Acres is run as an autonomous school with its own principal, four full-time teachers, seven part-time teachers, a school counselor, a nurse, a clerical staff and a custodian. The school day is divided into two segments: from 10:00 a.m. until noon all girls are required to take the Modern Family Living course taught by a certified home economics teacher and the school nurse; during the afternoon session, from 12:40 p.m. to 4:00 p.m., regular academic classes are held. Girls may take all subjects offered in the regular curriculum of their home schools, including advanced mathematics, sciences, psychology and sociology, black history and literature, and speech. Accounting, typing, stenography, and general business procedures are offered as electives in the business education curriculum. Classes are small and instruction is individualized to allow each girl to work and achieve at her own level.

Modern Family Living is a full-credit, multidisciplinary course developed especially for pregnant adolescents by the school's nurse and home economics teacher. It provides comprehensive consumer education--nutrition, menu planning, food purchasing and preparation, sewing, care and selection of clothing, budgeting, etc.--together with instruction on health and hygiene, physiology, prenatal and postpartum care, labor and delivery, infant care and child development. To apply their knowledge and practice their homemaking skills, the girls plan and prepare their own lunches. Films, field trips, and guest speakers supplement the course content.

Green Acres sponsors several extracurricular activities, including "Country Corner," a quarterly newspaper which features editorials, news items, stories, poems, sketches and recipes all contributed by the girls themselves. Once each semester the school holds a "Baby Day" when a special program is planned and students and alumna bring their babies to school. Each semester the school also holds a "gripe session" when students and staff meet over lunch to discuss complaints and grievances.

Green Acres' counselor is available to the girls everyday to discuss personal problems and situations on an individual basis. The girls' parents, husbands or boyfriends may also meet with the counselor at any time. The program instituted evening "rap" sessions specifically to include the girls' friends and families. At these sessions, the school's counselor, nurse and teachers lead discussions on such subjects as family planning, teen marriages, pregnancy, and interpersonal relationships. Additional social service assistance is available from the local office of the Iowa State Department of Social Services and the local Family and Children's Services. A volunteer in career education from Eastern Community College provides vocational counseling.

The need for proper prenatal care is stressed in all aspects of the program. Girls must have a doctor's verification of pregnancy to enter Green Acres and they must continue under a doctor's care throughout enrollment. The school nurse follows up on each girl to see that doctors' appointments are kept and that medical recommendations are followed. A nurse from the Maternal Health Center of Iowa University Medical School maintains close contact with the Green Acres staff and volunteers from Planned Parenthood and the Visiting Nurse Association supply supplemental health supervision whenever necessary.

Readings

All About Breastfeeding

Eiger, Marvin S., M.D., and Olds, Sally Wendkos, The Complete Book of Breastfeeding, Workman Publishing Company, Inc., New York, 1972.

If breastfeeding is the "natural way" (and who can doubt it), then why don't more American women do it? Look at the convenience: no bottles to wash, no equipment to buy, no formula to prepare, no waste and no risk of spoilage. And those are only the obvious benefits. Yet only 25 percent of all American women even attempt breastfeeding and well over half of them give it up after a short trial. Why the reluctance?

The authors of The Complete Book of Breastfeeding, Dr. Marvin Eiger, a pediatrician, and Sally Olds, a medical writer, offer several possible explanations. According to their research the three most significant reasons are probably the mother's expectation of failure, her "simple ignorance of the techniques" of successful breastfeeding, and the easy availability of alternatives. Modern technology in the form of dependable refrigeration, pasteurization and prepared formulas has provided the alternatives. The expectation of failure felt by many women interested in breastfeeding has more complicated and ambiguous origins.

In the United States, breastfeeding has not been the popular practice in some time, the authors point out; a new mother may never in her life have seen a woman nursing a child. She doesn't know the techniques of breastfeeding and may find her obstetrician or pediatrician less than eager to supply needed information. Often the nursing mother gets little support and encouragement from her husband, boyfriend, family or friends. Even to the most confident new mother these obstacles might seem insurmountable -- especially if her initial attempts at breastfeeding prove unsuccessful.

Those who work closely with school-age pregnant girls know that the natural apprehensions of pregnancy and motherhood are often magnified among adolescent mothers. Even girls who are eager to try breastfeeding may lack the confidence to follow through unless they receive good, practical information and special support for their plan. Therefore, it is especially important that those who work in programs for young parents be well prepared to give the needed assistance.

The Complete Book of Breastfeeding provides a fully researched, reasoned and reasonable means to this end. Written for nursing mothers, the book helps to increase their knowledge and aids in building the confidence and determination necessary for successful breast-

feeding. It also offers the new mother who is undecided about nursing the information she needs to make up her mind. The authors do not romanticize the subject nor do they harangue the reader. The book's tone and approach make it especially useful as a program resource. While both authors are decidedly in favor of breastfeeding and argue persuasively for their cause, they recognize that some women simply find the whole idea distasteful. "If you really don't want to nurse your baby, if the very idea repels you, don't do it," they advise. Their primary concern is that any decision a woman makes about breastfeeding be an informed decision.

They go about accomplishing this objective with authority and sympathy. The medical and scientific aspects of lactation are explained clearly and concisely, using simple yet detailed diagrams: how the breast develops, how it makes milk, how the milk gets to the baby, how breast milk differs from cow's milk, and how lactation may postpone menstruation and pregnancy. (In regard to pregnancy the authors caution that "while you are less likely to conceive" while nursing, there is no guarantee and "a contraceptive device is recommended for women who want to space their children.")

The authors know that the medical and physiological facts alone cannot always allay the fears and provide the assurances needed by an apprehensive new mother. What about sex? What about cigarettes, alcohol or drugs? Is it true that the DDT levels in mothers milk can be harmful to the baby? The authors explore these questions with frankness, offering facts and repeated assurances. Techniques for nursing are discussed with equal sensitivity and detail. The authors explain what to do if a mother has too much milk--or not enough, what to do for sore nipples, how to correct inverted nipples, how to tell if the baby is getting enough milk, how to hand-express milk. They discuss nursing and breast cancer. (Some studies have shown that nursing may actually decrease a woman's likelihood of developing cancer of the breast.) They point out that working mothers may also be able to nurse and explain how to plan a feeding schedule. A chapter is devoted to answering questions frequently asked by nursing mothers or those undecided about breastfeeding, and another chapter deals with "possible problems and specific situations."

In all of this there is still another aspect which receives the authors' full attention--the forgotten man. Nursing is usually a close, closed relationship for two. Though this book is primarily intended to strengthen that relationship by informing and supporting the baby's mother, the authors are aware that there is a third person who is, or can be, strongly affected by the interaction of the nursing couple--the baby's father. Like adolescent mothers, young fathers often experience new and frightening emotions. Too often young fathers, especially unmarried fathers, are left alone to deal with their fears. In The Complete Book of Breastfeeding a separate chapter "For Fathers Only," addresses these natural anxieties and apprehensions. The authors stress that such feelings are natural, that a new father "is not a monster...not a selfish brute... not immature for experiencing twinges of jealousy and hurt" after the birth of his baby. Many suggestions are offered to help the new father deal constructively with these new, painful emotions. His role is as demanding in its way as that of the new mother. By showing warmth, patience, and understanding, by offering support and emotional security, he can do much to ensure a successful nursing experience.

Discussing Sexuality

Kempton, Winifred, A.C.S.W., "Techniques for Leading Group Discussions on Human Sexuality," Planned Parenthood of Southeastern Pennsylvania, Philadelphia, 1972.

Discussing human sexuality isn't easy--not for individuals, not for groups and not for group leaders. For most people, it is an emotional, controversial, embarrassing topic riddled with misinformation, myth, anxiety and guilt. To lead successful group discussions, the group leader must be sensitive both to the subject and to those discussing it. This sensitivity is a product of knowledge and skill. The discussion leader must know the facts about the many subjects relating to human sexuality in order to provide accurate information, dispel misinformation, and guide the discussion so that participants will learn and not merely exchange opinions. But in this high tension area the most accurate information can be useless without good leadership skills and techniques.

The purpose of "Techniques for Leading Group Discussions on Human Sexuality" is to share approaches und procedures that have proven successful and to point out those that should be avoided. Though a short list of recommended readings is included, the author makes the assumption that the group leader already is well versed in the subject area.

The booklet is brief but specific. It begins with basic considerations such as the best physical arrangement for the meeting room. A warm welcome, large name tags and refreshments are mentioned as ways to "break the ice" and establish a congenial atmosphere.

While these suggestions are useful, they apply only to the beginning of the group leader's job. Once the discussion participants are comfortable in their surroundings and acquainted with each other, the leader must be able to follow through. "Start where the group is," the author advises. Stimulate the discussion, guide it with summaries and questions but do not expect the group to follow a planned agenda. They may not be emotionally ready to freely discuss some subjects, she explains, or some members may have misinformation or negative attitudes which would block discussion unless acknowledged and corrected.

By being flexible and imaginative the leader can introduce sensitive subjects without making the group members defensive or uncomfortable. Play a popular record and discuss the words and their implications, the author suggests, or discuss a movie or a newspaper article. Help the participants avoid the embarrassment of appearing ignorant by asking them to anonymously submit written questions and topics for discussion.

The booklet contains many other practical tips for promoting open and constructive group interaction, but it also spells out techniques and approaches that should not be used. As the author points out, group members must feel free to verbalize their feelings in "whatever terms they are comfortable with;" the group leader should not "insist that only 'proper' words be used." Moralizing is especially damaging to frank discussion; the leader's role is to present alternatives and explain their consequences, not to set or judge moral standards. Each person's values, attitudes and feelings are an inseparable part of his or her sexuality. The group leader who fails to recognize and act on this fact will be ineffective according to the author.

Single copies of "Techniques for Leading Group Discussions on Human Sexuality" cost 60 cents and may be purchased from Planned Parenthood of Southeastern Pennsylvania, 1402 Spruce Street, Philadelphia, Pa. 19102. Bulk rates are available.

IMPROVING CARE FOR INFANTS OF SCHOOL AGE PARENTS

BY LINDA L. JENSTROM

A SUMMARY OF TWO INVITATIONAL WORKSHOPS

Sponsored by

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Introduction

For the past several years the Consortium on Early Childbearing and Childrearing has been working throughout the United States to initiate and improve services for school-age pregnant girls, young parents and their infants. When the Consortium (formerly the Cyesis Programs Consortium) began in 1968 its activities were directed principally toward helping communities develop continuing education services for school-age pregnant girls, with added emphasis on the special health and social service needs of this population. Over the years the Consortium has helped programs develop, both in number and in the quality of services they provide. In 1968 there were approximately 35 programs designed to meet the needs of the pregnant adolescent. Today there are approximately 250 such programs.

As the number of programs has increased, so has the scope of their services. At the same time, it has become apparent to many programs that provision of services during pregnancy is not enough. Adolescent parents have needs that go far beyond the immediate needs resulting from the pregnancy. As a result, a number of programs have instituted alternate care arrangements for infants and have designed curricula to support and inform the adolescent about the responsibilities of parenthood and the processes of child development.

In the spring of 1972 the Consortium, through funds granted by the Office of Child Development, sponsored two small workshops; one in Washington, D.C. on April 27 - 28 and another in San Francisco on May 3 - 4. Selected to attend were 70 representatives from programs operating or planning to operate services for infants of school-age parents. The planning committee agreed that for maximum participation, each group should be no larger than 35. In order to obtain a good cross-section of opinion, all regions of the country were represented at both workshops. The agenda at both workshops was similar.

The purpose of the workshops was twofold: First, to improve the quality of care received by infants in newly instituted alternate care settings; and second, to obtain the clinical experience and observations of those who had been working with young parents and their infants. A literature survey conducted by the Consortium had disclosed little or no existing research on adolescent parenting practices. Therefore, in an attempt to establish a knowledge-base useful to those contemplating or engaged in such programs, it was essential to bring together people who had actual experience in dealing with young parents and their infants. It was also hoped that program representatives who were planning or engaged in actual services would benefit from an opportunity to share ideas, problems, and successful experiences.

In an extensive survey of programs serving adolescents conducted prior to selection of the workshop participants, it was found that those programs which had decided to extend their services to include child care arrangements had primarily opted for group care. More than 90% of the programs represented at the workshops had selected this option. This may or may not reflect future choices of other programs. The reasons for this choice and an analysis of other options are presented in the summary of workshop discussions in the section on Infants, p.40.

In selecting the workshop participants an attempt was made to invite individuals working at a variety of levels within several different program models serving school-age parents and their infants. These included school principals, program administrators, teachers working with adolescent parents, directors of infant care centers not associated with programs for school-age girls, and those engaged in actual caregiving tasks. By discipline, about half the participants were educators, one fourth were social workers, and the remainder were physicians, nurses, child development specialists, paraprofessionals and community organizers. Since most of the participants were providing group day care for infants, speakers for both workshops were selected from leaders in that field. However, their remarks can be applied to other forms of alternate care situations.

Summaries of the participants remarks have been grouped according to topic. Since participants in both workshops were asked to discuss essentially the same questions, related comments have been grouped together. The material has been organized into two main sections; the first deals with parenthood in adolescence, and the second relates to the needs of infants of adolescent parents.

Only those who have listened to tape recordings of days of discussion and have worked with massive numbers of pages of typed materials can fully appreciate the task of writing this summary which Linda L. Jenstrom has so ably completed. The actual writing constituted only one part of the effort that went into its production. Through her work with school-age pregnant girls, Marion Howard, former Director of the Consortium, became aware of the lack of knowledge concerning the child-rearing practices of adolescent parents as well as the need to provide programs serving adolescent parents and their infants with information and support. Once the task had been conceptualized, Tannis M. Williams, Ph.D., lent leadership and support throughout the planning and convening of both workshops.

Subsequent to these workshops in July 1972, the Consortium became a special project of the Child Welfare League of America, Inc. With its long commitment to advocacy for children, the CWLA has developed a number of written materials relevant to this workshop discussion. The reader's attention is called particularly to: *Child Welfare League of America Standards for Day Care Service*, revised 1969 edition, and *Guide for the Care of Infants in Groups* by Sally Provence, M.D.

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CHILD DEVELOPMENT, INFANT DAY CARE AND ADOLESCENT PARENTS

A National Overview

by Charles Gershenson, Ph.D.

Former Director of the Office of Child Development's Division of Research and Evaluation in the U.S. Department of Health, Education, and Welfare, Dr. Gershenson is currently a visiting professor of Child Development at Brandeis University and Director of the Young Child Study, UNICEF (United Nations Children's Fund).

In his opening remarks Dr. Gershenson set the framework for the discussion by providing some statistics indicating the magnitude and severity of school-age childbearing in this country.

"Figures from the last decade indicate that the number of births to those under 18 years of age have, on the average been increasing by about 3,000 each year. Thus in 1972, we can expect that over 213,000 girls of school age will give birth to a child." He noted that a number of factors may be contributing to this trend--the sheer increase in numbers of teenage girls in the population, improvement in nutrition, and perhaps the decrease in the age of menarche. However, he cautioned that the latter trend appears to be leveling off.

In terms of conceptualization of the problem of school-age childbearing, Dr. Gershenson indicated that there has been much progress. Four years ago the primary social problem was considered to be the unmarried adolescent. As more information was gathered, it was found that 60% of school-age mothers were married. However, he noted, "We learned that being married does not diminish the high educational, social and health risks of early childbearing. Moreover, many of the marriages occur after conception, in a forced situation, with the result that over half of such marriages end in divorce within the first five years." The concept that the problem of school-age pregnancy is part of black culture is another idea that is being examined more closely. In reality, Dr. Gershenson noted, the problem relates to the total society. Sixty percent of school-age mothers are white, the remaining come from other ethnic groups. Approximetely 85% of school-age mothers keep and raise their children.

In dealing with problems related to early childbearing, he noted that there has been a change in understanding about the critical issues. When programs were first instituted to meet the needs of this population the primary goal was to enable the young pregnant girl to continue her education during pregnancy. It has since become apparent that continuing education during pregnancy will not suffice to meet the needs of the school-age parent if the parent is unable to return to school after childbirth. He pointed out that many programs began to consider providing care for the infants of school-age parents primarily to help young parents attain their educational and vocational goals.

Dr. Gershenson told participants that their work in programs for young parents has placed them in the forefront of social change. "You are engaged in something which I call institutional change. You have looked at a particular category of young people, and you have looked at our institutions in terms of their ability to meet the real human needs of these young people and said: 'The institutions are inadequate, they are destructive and therefore it is time to change them. We think we know what the needs are and we intend to do something about it.' And in so doing you have undertaken to change the most rigidly entrenched and strongest institutions in our society, namely the health system, the educational system, and the welfare system. Moreover, you have had the courage to take on all three simultaneously....By your unhappiness with the treatment that schools have traditionally given this population group, with the low priority and inappropriateness of care often rendered by the health system, and with the priorities social service systems have given to those placing their baby in adoption and the neglect shown those who marry and/or live at home and keep their baby, and most importantly by your willingness to do something about it, you have had a much greater impact than you may realize. You are operating in programs which represent some of the most meaningful institutional changes that are occurring at the present time."

Dr. Gershenson outlined a model for institutional change, noting that many of the participants were actually using such a model without being aware of it. This model for institutional change contains five basic components: perceived social need, adjusted social need, social policy formulation, program development, and evaluation. He emphasized that program developers at both the national and local levels should realize the importance of using such an explicit theoretical model.

He defined the perceived need as that particular societal problem that a program developer, researcher or consumer identifies. "For example, many of you have said that in order to help the girls in your programs continue in school, you have to provide an infant care program." This is a perceived social need. The critical thing, he noted, is to properly identify it as a perceived need.

Dr. Gershenson cautioned that by focusing program development efforts on the perceived social need alone, it is possible to overlook some critical steps in the process of social change. He noted the tendency to focus only on the perceived social need without a thorough thinking through of the need as it relates to historical, social and theoretical contexts. As an example, he presented quite a different view of providing infant care services for school-age parents. "I could perceive the need from a child welfare viewpoint and say, 'We need infant care because the girls may not be adequate mothers; therefore, we need such care for the protection and survival of these infants and also

to provide a setting in which to teach these mothers about parenting.' " He then described the kind of thinking which would help to identify the real issue: "Is the issue continuation of the mother in school? Is the issue the well-being of the infant? Is the issue the family and the role of the father in this process?" This type of thinking-through process can result in what he termed the adjusted social need.

After finding the fundamental issue--the adjusted social need--the process of social policy formulation begins, according to Dr. Gershenson. In describing social policy formulation, he noted that the most fundamental problem is that "the demand and need for money, staff, facilities and so forth will always exceed what is available." Decisions regarding priorities can only be made by those designing programs, nevertheless such decisions must be made if the program development is to proceed. The decision-making process involves a review of the social needs, a review of possible resources and the setting of priorities.

Program development is the next step in this process. Dr. Gershenson outlined some of the basic decisions to be made in order to implement the priorities set by the policy formulation process. Among those he listed were: what kind of facilities will be provided, where will they be located, what kind of staffing will be involved, what kind of curricula, who will or will not be admitted to the program, and finally, how comprehensive is the program to be.

Evaluation is the final portion of the theoretical model outlined by Dr. Gershenson. He differentiated two types of evaluation: formative and summative. Formative evaluation is used by program directors to improve their programs as they develop, to examine the effectiveness of the internal operation of the program and indicate areas which need change. Summative evaluation measures how effectively the program addresses the social need. He pointed out that both types of evaluation should be used to analyze the perceived social need, thereby affecting the process of social policy formulation and the direction of program development.

Dr. Gershenson ended his remarks with two major points. The first involved the development of practices that are relevant to various ethnic and racial groups. "Particularly if you are working in the area of childrearing practices and the development of family stability, you must be sensitive to this issue," he said. "It is well to bear in mind that a lot of the myths of the black family, the Puerto Rican family, and the Chicano family have been exploded. The concept of cultural deprivation popular in the '60's is now discarded. There are many strengths in these families and we must recognize them. ...One of the worst traps you can get into is to develop a model and then be accused of trying to impose a 'white middle-class value system' through your childrearing methods."

Finally, Dr. Gershenson pointed out the lack of research concerning adolescent parenting practices. While he noted that much research is available on infant development, the clinical experience of the workshop participants was the most critical source of information about adolescent parents. "This very workshop is a mechanism to tap your experiences in the field which are far ahead of our research efforts. However, because you are in the forefront of knowledge and program development let me reiterate, it is all the more critical that you think through clearly what the truly germane issues are and zero in on the appropriate needs."

Meeting the Needs of Adolescent Parents

The participants were asked to address themselves to a variety of issues concerning school-age parents: how they feel about themselves as people, and as parents; what part comprehensive programs can play in their lives and in the lives of their infants; whether adoption is a viable option for teenage parents. Some of the questions raised at both workshops and the various points made by participants are summarized below with individual comments indicated by an asterisk.

Pregnancy in Adolescence

At both workshops the participants were initially asked to discuss the motivation for adolescent pregnancy. The answers can be categorized in two parts: Often adolescents don't know enough about sexuality to prevent pregnancy and those adolescents who do have adequate information are often seeking for something outside their immediate experience.

Why do some adolescents become pregnant at such an early age?

* "In many instances, with the older girl there is a continuing relationship with the father of the baby. However, particularly with the younger girl, you find that sometimes she is pregnant because she didn't know how you GET pregnant."

* "We have found, at a university hospital, that the girls in this age group need a good deal more information about the simple facts of reproduction. From their own testimony it is evident that they are not at all sure they are risking pregnancy when they have intercourse. If they do receive the basic information, they somehow deny it. In working with these girls it is necessary to go back to the most fundamental reproductive information, rather than simply suggesting some method of contraception."

* "I think what is needed is education early in childhood about sexuality, family planning, and so forth, for both boys and girls in a school situation. They need to know about the realities of sexuality."

* "My question is, recognizing these needs, how can we approach an existing institution or agency and begin to change their attitudes? How can we make an impact upon the school system to improve their educational curriculum so that young people will understand sexual activity and their role in it?"

* "In my school district we talked about changing the school's attitude about educating youngsters about sexuality and contraception. We had a school that was ready to institute a program and had funds to implement it. The program was never

instituted because there were parents who did not want their nice little girls taught anything about sex. Any attempt to bring sex education into the community was completely blocked. Who has the problem? Is it the school-age parent or the grandparent? Perhaps we should place more emphasis on educating the parents of sexually active school-age youth. If the schools are ready, then we must find a way to change the attitudes of the parents."

* "What about those adolescents who do have adequate information about sexuality?"

* "Perhaps pregnancy at an early age is a result of a search for a relationship that is missing in the mother-daughter relationship. A good relationship between the girl and her mother is often lacking. As a result, the girl searches for acceptance and affection from a boy. When she bears an infant she is again looking for a relationship which she has not had. Our goal should be to break into this cycle and, beginning with the young mother-child relationship, prevent this cycle from repeating."

* "Really, this is how social workers explained pregnancy 15 years ago. But there are other views which we might examine to see how they fit into our experience and practice. One is that regardless of how you get introduced to it, sex becomes fun. It may not have affectional ties. It may or may not be with one person. The other view is that the girl may have a very poor self-image. Because of her lack of confidence she may passively comply with requests. In other words, it is simply easier to say yes than to say no."

* "I can't believe that so many of us who have worked with young mothers don't sense that their self-image is a very low one, a very poor one. They don't feel that they are really worthy human beings."

* "A 17-year-old who has been involved with a young man for several years and is contemplating marriage simply may not want to wait."

* "The unconscious and conscious motivations which have been mentioned may certainly apply to some of these girls, but there may be other girls who really just do not accept the fact that they are sexually active and, as such, literally get caught."

* "We recently had some discussions with some girls about why they involved themselves with sex. In one group they listed 26 reasons, none of which had to do with getting pregnant. I think that we have to separate the motivation to belong from the desire to have a child."

* "We always talk about the unconscious motivation of the girl and forget that it takes two to rumba. What about the unconscious motivation of the boy?"

* "I feel that by becoming sexually involved a girl feels cared for. The father, in turn, having sired a child, feels that he has something of his own. The need to have something of one's own, to feel love, to have a sense of belonging to someone is the most common motivation."

* "I would agree that one of the major motivations for young fathers to sire a child is the need to produce something of his own. But the young girl's motivation is simply to be cared for in some kind of relationship. She is not thinking that in nine months she will have a baby. What we are really talking about is motivation for sexual intercourse. Everything else becomes secondary."

* "As I listen to you talk it occurs to me that we are not talking about a young mother, we are talking about an adolescent. Everything that has been said is representative of adolescent needs, peer group acceptance, need for love, and building up of self-image--all are adolescent needs. When we talk about the young mother we had better be very knowledgeable about adolescence because that is what we are really talking about."

* "I would like us to think for a minute about this whole concept of self-image. It goes far beyond just the girl who gets pregnant. It permeates our whole society in terms of how we treat people. There are many things we should be concerned about. We must begin to realize that we have to humanize the way we treat people. We have to begin to help each other value people as human beings. In our schools we dehumanize people while we are supposed to be educating them. Somehow we have to turn our society around so that we value people."

* "Perhaps we have created a society in which the only thing that a young person can do is produce another someone. One way to wave a flag and say, 'Hey, I am someone,' is to have a child. In most instances this is self defeating. Basically, we are not developing good self-concepts in our children."

* "I see two topics being talked about here. The first one relates to our job--what to do for girls after they become pregnant and decide to keep their child. The second topic is larger, dealing with the entire societal structure. I think that perhaps this topic is really the job of some consciousness raising group that should start working with the adult community towards changing attitudes."

"Many of the things that have been said have been our own adult moral reactions which we are placing on teenagers. In short, we've implied, 'You are not allowed to do it.' Adults don't seem to understand that you can not stop sex by edict."

* "I agree. As I have listened to this discussion I have had the feeling that we were talking about a group of people who are not like other people. We have implied that it is fine for us to engage in sex but if you are 16, there is something wrong with it. I think that people have had sexual relations from the beginning of time because they were in love, because they wanted to belong, because they were close to someone, because they wanted to father children. Women have wanted to become mothers for age-old reasons and we have been talking about those reasons. Yet we are putting them in a negative context because of the youth of the people involved. I think we should remember that 100 years ago it was quite acceptable for a girl of 16 to have a baby. By that age she was often married and working on a farm. Our society has changed and has decreed that having a baby at age 16 is now bad. I think that if you ask a teenager why she got pregnant or had sexual intercourse, she is goi ng to think up a reason for you. I don't think you would ask

a woman of 30 why she had sexual intercourse or got pregnant. Asking the question is rather foolish."

How do you think a school-age pregnant girl feels about herself as a person?

* "Her coping mechanism is often not up to par with those girls in the regular school program. I think we lose sight of the fact that adolescence itself has many developmental phases. Pregnancy just makes the whole process of the teenage girl's development more difficult. In addition to attaining her own developmental goals, she must learn to cope with the difficulties surrounding her pregnancy."

* "A large part of our program is directed at simply improving the girl's self image. We work with each girl on an individual basis and at her own level."

* "Over and over our psychological testing shows poor self-concept. We try to identify within each girl her most positive attributes and build on those. We try to help her begin to feel that she is somebody and to help her set her goals higher."

* "I am somewhat confused on this matter of self-concept. Girls in our program have said, 'We have a good concept of ourselves but you, as our teachers and our parents, do not have good concepts of us.' "

* "I think that conflict exists within the pregnant girl herself during pregnancy. In some ways she feels good about herself, but in many other ways, because of the values of society and religious mores, she feels very guilty."

* "I think we must also differentiate between how the girl feels about herself as pregnant and how she feels about herself as a mother. There is a vast difference. Often when a girl becomes pregnant she suddenly receives a lot of attention. She may really be enjoying the state of pregnancy but may not be anticipating motherhood. The actual state of motherhood may produce very different feelings."

* "The girls in our program seem to require a great deal of mothering from our staff. They do not have this type of rapport with their own mothers. In many cases the pregnancy has aggravated what was already a damaged mother-daughter relationship."

How do you think the young mother feels about her role as a parent?

* "The adolescent mother differs from an older mother in the same way that an adolescent differs from an adult. She is still under the authority of a parent. Emotionally she is still somewhere between childhood and adulthood; therefore she is more likely to be ambivalent about her relationships with others. She is more inconsistent in caring for her child. She loves him madly one moment but considers him a tremendous burden the next."

* "I agree, although I don't know how much we can generalize on this particular point. The adolescent mother seems to vacillate from periods of love and feeling very

solicitous for the child to periods of very strong withdrawal, punitiveness, and simply 'not wanting to be bothered' by the child. I know that these are normal kinds of feelings among parents generally; however, it seems to me that with the adolescent parent these feelings are exaggerated."

* "When an adolescent mother does assume the parenting role, her attitude toward her infant changes over a period of time. During the first three months of the infant's life she regards the baby as a doll. She is completely fascinated with him. However, as the child grows the responsibilities grow. At three or four months the baby slowly begins to get in the way. As soon as the baby becomes a little person rather than an object he ceases to be so fascinating."

* "We have seen girls resign from the role of mother almost immediately after giving birth. She has been uncomfortable for nine months, particularly during the last few months. After the baby is born she is even more uncomfortable. Her physical problems are very real and they are due to the fact that she has become a mother. Before, as a teenager, she had none of these problems."

* "She has feelings of inadequacy as a mother. Actually, she is inadequate. Most young girls simply don't know how to care for a baby."

* "It is difficult to generalize, but most young mothers seem to believe that a parent must meet the physical needs of the child and be a strict disciplinarian. They have very little concept of what mothering actually is. This tends to be more true of the very young mothers."

* "Adolescents tend to be a little bit self-centered. We have found that some of our young mothers regard the baby as a possession rather than as an individual. It seems to be difficult for them to realize that the baby is an individual and is going to have a life of its own."

* "Although I really don't have a lot of evidence, it appears to me that older parents have more of a 'fun relationship' with their children. It seems that the younger parents do want their children and see raising the child as a responsibility, but the older parents really see their relationship with the child as something enjoyable; something they are willing to spend time, a couple of hours each day developing. In contrast, I'm not sure that the younger parents see play time with the infant as something important and something they want to do."

* "Perhaps one of the reasons that the younger mother does not see the tasks related to childrearing as enjoyable is that she considers the child an obstacle, in many instances, to her own developmental goals. The infant or child can be an obstacle to continued education, to acquiring a job, and even, if the young mother is not married, to establishing a long-term relationship with a young man leading toward marriage. Therefore, the young mother cannot be as pleased with the child as she could be if he were not such a complicating factor in her life."

* "We have assumed that mothering is an instinctive thing; that once a woman has a baby she will be able to care for it. This is simply not true. We are going to have to look at group parenting or some other way of mothering that will provide support for the young mother. Too often, she has had no symbol of mothering in her own life. She is not going to become a good parent automatically. Therefore, we have to find ways in which our society can share the mothering task with her."

* "I would like to suggest that we address ourselves not just to the problems and the weaknesses--the particular constraints--of being an adolescent parent but also to the strengths of adolescent parenthood. One of the most important things that we can do is look for the positives as well as the negatives."

* "Adolescent mothers do have some strengths. They have a tremendous amount of physical energy and adaptability. We can build upon these strengths by assisting each mother to develop a series of skills which will enable her to cope with the situation."

* "I would take some exception to the notion that all young mothers are totally inadequate. We have some girls who take beautiful care of their infants. Often they are the older child of a large family and have learned some of the basics of caring for a child."

* "We have identified some strengths and some deficits which these young mothers seem to have; but we are on rather dangerous ground. We have focused on individual cases and then generalized to the young mother. We could easily build stereotypes that are not based on fact. In our society we have done that with every other group of people on which we have focused. We should not make that mistake again. We don't have information on large numbers of young mothers. We haven't observed them over long periods of time. We must be very careful about our subjective opinions. Too often we remember only the cases that stand out because of some deviation from the norm. We must not build a model of the young mother that way."

How does the age of the young mother affect her ability to successfully assume the mothering role?

* "If we are going to discuss the very young mothers, it is important to note that many of them do not really feel that they are mothers. If they live at home their own mother--the infant's grandmother--often assumes the parenting role. As a result, the infant is raised as a sibling of the mother."

* "Often, however, the girl must still accept some responsibilities for her child as well as live within the rules of her own household. She is told when to go to bed, how much time to spend on homework, etc. Simultaneously, her mother--the grandmother--or other family members may say, 'This is your child; I have looked after him all day and therefore you will not go to the ball game this evening but stay home and care for him.' The young mother is not able to make a decision for herself and must live with many restrictions. This type of conflict can begin to transcend any feelings of motherhood and lead to resentment of the child."

* "When we talk about a 10- or 11-year-old girl who has a baby we are not talking about someone that we should try to train to be a mother. Such a situation presents a very special problem. The needs of the infant have to be met. The girl, who unfortunately has become a mother, has got to be taken care of, too. What we may say in general about programs for adolescent mothers really does not apply to a 10- or 11-year-old girl."

* "If we carry this argument out to its logical conclusion, it seems to me there are two alternatives for the adolescent mother/child of 11, 12, or 13 years. One is placement of the baby through adoption and the other is sibling status for the baby. In other words, the grandmother assumes the mothering role completely. "

What then are the implications for the services we provide?

* "Some of us seem to be saying that we should not provide services to this younger age group simply because assuming the parental role will be too much of a burden for them. We seem to be implying that they should not have the opportunity to assume the parental role, that our society should deny that opportunity to the younger girl wherever possible."

* "Perhaps what we are suggesting is that, with the younger girl, a service program has got to meet the needs of the total extended family. If a 17- or 18-year-old girl becomes a mother, the grandmother or other members of the extended family may act very differently than they would if the girl were 11 years old."

* "I don't see how we can really arrive at a definitive statement by using such generalizations. We are saying that girls don't get support from their mothers. I have observed that many girls get a tremendous amount of support from their mothers. We must continually keep in mind that we are making generalizations and that in any given instance the individual needs of the girl, her baby and her family should be met."

* "What we are saying is the needs differ for different age groups, as well as different levels of maturity--among young mothers. We have said that in many instances there are very young girls who should not be mothers. Conversely, there are adolescent girls who are mothers and who will function effectively as mothers."

How does the cultural and family environment affect the young mother's feelings about her role as a parent and her competency as a parent?

* "Again, we must be very careful about generalizations. There are many cultural variables which are directly related to the young mother's feelings and her competency. In the Navaho culture, for example, a 14-year-old girl who bears a child may have raised three or four younger brothers and sisters. Further, the Navaho culture includes a basically nondisciplinary family relationship."

* "We must consider how much of the child care model comes directly out of family experience. Many of our young parents are probably simply doing things the way they have seen them done in their own families."

* "In our area we are seeing replication, particularly concerning discipline. But there are changes. Our young parents are not as punitive as their parents seem to have been with them."

* "There is a definite cultural effect. We have a mixture of Mexican and white young mothers. Our Mexican mothers definitely want to imitate their mothers and they do to a remarkable degree. Our white mothers generally have a feeling of rebellion. Actually, they imitate their parents while saying that they hate their families and intend to treat their babies differently."

* "We may have common educational, health, and social service goals, but when we plan a program the delivery of services should be integrated into the family structure. Moreover, the delivery of services to a Mexican-American girl, a black girl, an Indian girl, and so forth, should be tailored to meet her specific needs. The overall problem is how we deliver services based on the ethnic background of the consumers. Doing this sucessfully is the responsibility of the agency delivering the services."

Programming

During the past decade communities around the country have been increasing efforts to deal comprehensively with the needs of young parents through special programs which provide educational, health, and social services. There are currently more than 250 such programs serving school-age pregnant girls and young parents. In considering the various facets of these programs, the workshop participants discussed such issues as regular schools vs. special schools, program administration, how the new abortion/contraception laws may affect programs, and how programs can deal with repeat pregnancies.

The following questions were among those highlighted during this discussion:

What are the relative strengths and deficiencies of providing special schools for pregnant adolescents rather than allowing them to remain in regular school?

* "One major factor is whether or not the supplementary services which exist in a special school are provided in the regular school. The key question: Is it possible to coordinate the health care, social services, and special educational requirements of young parents within the regular school setting?"

* "We should make alternatives available. Each girl should have the opportunity to make a choice between remaining in her own school or entering a special school. Hopefully, one day we will not need to have alternative schools because we will have educated the administrators, counselors and teachers in the regular schools to be more accepting of young parents. At this time, however, the attitudes of school personnel can be extremely damaging to a pregnant girl."

* "The difficult thing is that after delivery the young mothers are supposed to return to their regular schools. The regular schools operate on a full-day schedule while the special schools teach a full curriculum from 9 a.m. to 12 p.m. The young mothers in our program often ask, 'You have told me that I should spend some time nurturing my baby. How can I do all the things you have taught me and still continue in regular school?'"

* "I think there is a need for a separate program and there is also a need to give the girls a choice of programs after they deliver. In our district we have a special program run in conjunction with the adult school. After the girls deliver they may go back to their regular school, join the adult program or under certain conditions they may continue for three semesters in the special program."

* "Knowing that the number of very young girls who become pregnant is growing each year, we must begin to think about providing more protection and advocacy for the younger girls. Most elementary schools won't put a Kotex dispenser in their bathrooms for fear that it will promote pregnancy. In our program we have served five ten-year-old girls within the past two years. I would hate to see any community give up a special program for school-age girls simply because the regular schools agree to allow pregnant girls to remain in school."

<u>How will the new abortion/contraception laws affect the population of programs for school-age pregnant girls?</u>

* "There is no doubt that abortion is going to be increasing in this country with a further liberalization of laws and it is going to make an impact upon programs. As I conceptualize it, we may be faced with a different kind of population of young women who have different motives for childbearing. For example: I wonder if we won't see a shift downward in age with more 16, 17, and 18-year-old girls opting for abortion, and those between the ages of 11 and 15 not obtaining abortions."

* "If we are going to talk about the 10 to 14-year-olds, we are literally talking about children. The availability of abortion to them is really almost mythical. By the time they recognize and acknowledge their pregnancy it is literally too late. Further, they have no knowledge of the alternatives available to them."

* "We all know that most of our young mothers do not go to a physician until they are quite well along in their pregnancy. First, they don't want to tell anyone and secondly, they have the fantasy that somehow they are going to hide the pregnancy. I think there are some who feel it will go away, like mumps."

* "I also believe that the reason we are getting more applications from younger girls in our program is that the 16, 17, and 18-year-old girl is becoming more responsible about using whatever contraceptive method she has chosen with the advice of her doctor."

* "In terms of birth control, I think a big part of the issue is that in order for a girl to obtain some form of contraception she must acknowledge to herself something that I don't believe many adolescent girls are willing to acknowledge."

* "I concur. In talking with young girls I have found that many do have knowledge of contraceptive methods. When asked why they don't use them the response is that it would be immoral. If they used contraception, it would mean that they had planned to have sexual intercourse."

* "I think there are strong cultural patterns and value systems which are very relevant to this discussion. There are some groups of people who are not going to permit anyone to tell them how many children they should have no matter what you tell them about their economic status. Cultural beliefs or religious beliefs are far deeper than economic considerations. Right now in black society this is particularly true. There is a lot of black literature opposing the various forms of contraception devices and birth control measures, linking them to a very definite fear of genocide."

* "In my work with the Navahos I am finding that their leaders do not want any form of birth control or abortion available to their people. I can understand the point since there are only 130,000 Navahos. They do need more people. However, they also have a fifty percent unemployment rate. In this situation, one key word is 'imposing.' Advising people of the possibilities is one thing, but imposition of a birth control program definitely intimates genocide."

* "Speaking from my knowledge of federal programs, the family planning legislation reads that you cannot impose family planning on any recipient of welfare or any other federal program. The legislation is specifically written so that 'imposing' is not an issue. In the past there were no services, no options, no choices. The poor did not have access to the options of the middle class. Now through family planning programs most women can make their own judgments based on their own value systems."

How can programs deal with repeat pregnancies?

* "For years, study after study showed that we could predict that 50% of the girls who bore a child at an early age would have a subsequent unwanted pregnancy within the next two years. Studies in New Haven, Conn., showed that in five years 100 girls had 349 pregnancies. However, the Webster School, in a special program for pregnant girls in the District of Columbia, demonstrated that it is possible to make an impact on repeat pregnancies through counseling. At that point in history, the school system had a regulation prohibiting family planning instruction in the school.

In addition, there was not the kind of popular acceptance of and federal support for family planning services that we have today. All that was available to the girls in the Webster School was counseling.

"Subsequently, we learned that if you provide contraceptive services for adolescents but don't provide counseling, you may get a 100% dropout from the family planning services. A study has shown by providing both counseling and family planning services, the repeat pregnancy rate can be reduced from 50% to 10% or 15%. In other words, a large number of the girls in this particular study were not having unwanted pregnancies and thereby complicating their own life situations. This, I think, is a very significant difference and it occurred because the girls had options they had never had before."

* "I think repeat pregnancy is a serious concern. It is much more difficult for a girl with two or more children to graduate from high school or go on toward higher education. I think there are two possible positions a program can take. It can allow the individual girl to make her own decisions about birth control with a minimum of advice and information; or it can take a more aggressive point of view which holds that a series of pregnancies during the high school years may have very negative consequences on health and self-fulfillment and therefore the program needs to be strongly directed toward birth control."

* "I think it is fine to simply give out information on birth control methods and teach the young parents about reproductive processes, but it is equally if not more important to have a follow-up program for young parents. They need someone to help them with their day-to-day problems and their attitudes and practices regarding birth control."

* "This is particularly true with younger girls. It has been my experience that many of their parents are against their using birth control. In spite of the fact that our young people do not need parental consent to receive birth control counseling and medical help, we still are faced with a group of young people who are part of a family and answerable to family wishes."

* "We should also be aware that some girls in the 11 to 14 age group may want to take responsibility for the care of their child. If they are not given the kind of assistance that will enable them to take this responsibility, the grandmother or some other member of the extended family takes over the care of the child. The solution for the adolescent may be to become pregnant again in order to become fulfilled with a child of her own. These are the girls who are most likely to have a second baby."

* "I have found when I follow up on our younger girls there is a definite time sequence related to their use of contraceptive methods. When the baby is first born it is like a doll to them. Two weeks later the grandmother begins to absorb the baby as her own. For the first six months the young mother takes her pills or has her IUD checked but when I go back for later visits they will say things like, 'I forgot to get

my birth control pills refilled this month,' or 'I skipped my visit to the doctor.' It is almost as though the childbearing experience is forgotten because the baby has been absorbed by and is being reared by the grandmother. I feel we must constantly follow-through and reinforce the use of birth control for the very young mothers."

What are our general goals in programming for young mothers?

* "Our program is totally oriented toward the girl; we work every day around those areas which are of real importance to her. We begin at her level, working with what she brings to the program. I think this is how you help her build the kind of self-control and self-reliance she needs to go back into the community and deal with the minor and major issues in her life. We constantly work toward developing a feeling of self-importance and increasing the girl's ability to control her life."

* "It seems to me that the girls we are working with are somehow caught in a downward spiral. The important thing is to try to reverse the direction of that spiral. But it is a slow process; it has taken generations to produce, and it is not easy to move it in the other direction. Our program uses a sort of behavior modification technique in which the girls receive points for participation in various activities. These points can later be traded for clothing, material, baby clothes, and so forth, in a small store that we run."

* "I think there is some disagreement on the effectiveness of offering tangible rewards based on performance. Often programs reject this method because it seems too materialistic, yet there is some evidence which suggests that this approach often has a very high payoff."

* "I think we must ask ourselves a few questions. Whatever our program goals are--education, developing parenting skills--who decides how to set them and how to implement them? Do we simply accommodate to whatever the girl wants to do? Do we fit the program nicely around the girl to fulfill her needs as she sees them? Or do we work out with the girl what we think is in her best interests? It seems that we demonstrate a tremendous amount of flexibility and ingenuity, but I wonder if it is directed toward specific goals? What is it that we are trying to do for these young mothers?"

* "Let's consider the first area, that of social needs. A high-priority social need, it seems to me, should be to involve the consumers--the girls themselves--in the crucial decision-making process."

* "I think we must come back to the whole issue of adolescence as a period of developmental crisis. One of our goals should be to help the young mother deal with those issues confronting her. We must keep open the flow of communication between the staff and young mother so that the staff can deal quite directly with her most pressing personal problems. Further, what she considers priority issues may not be what the staff considers priority issues. Nevertheless, we must deal with those things which most deeply concern the young mother if we intend to make any progress."

* "We all want pregnant girls to have optimal health care and produce healthy children. We want to help the girls continue their education or participate in a training program that will enable them to live happy and productive lives. We want to help train and support them in their parenting role. We want to teach them principles of child development and nutrition. We want to support them in their social needs and family problems as well as their interpersonal problems. We want to help them see the wisdom of planning their future families. We want to help them understand sexuality and to know when and how to use contraceptive methods. We all agree on these goals. But we should also consider carefully how much goal setting can be done by programmers as opposed to how much we accept the young mother's self-determined goals. We should also consider how these goals can be made culturally appropriate."

<u>How can a program headed by white administrators serve other ethnic groups who may have different cultural values?</u>

* "The issue is whether or not there are different principles which must be applied when you deliver services to people from different cultural groups. Everyone wants to have a quality program. However, we must decide if quality means a different thing for different cultures, or if quality is quality regardless of culture."

* "We have said that one of our goals is to help the young mother feel good about herself. How can a teenage mother feel good about herself if the program throws her into conflict with her culture? We must have people in our programs at all levels who understand and represent her cultural values and who will safeguard those values."

* "I don't agree that a quality program means that a girl does not come into conflict with her cultural values. Nor do I agree that in order for a girl to feel good about herself there must be no conflict with her values. If we went through life without any conflict we would be in bad shape. I also think that values vary greatly within cultures and if we asked each person in this room what the values of his own culture were we would have many different ideas."

* "Some things which you could call cultural values can be damaging to the child. For example, good nutrition is necessary for healthy growth and development. If the mother, because of her particular life style, does not recognize the need for good nutrition, what do we do? What are our responsibilities when we are told, 'We are going to rear our children as we were reared and we will not give up this food for some other food.' "

* "It is simply a matter of education. All of the things we have discussed are not related to teaching attitudes or values; they are related to teaching basic child-rearing skills."

* "We cannot claim to be teaching skills while not involving attitudes and values. When we talk about bathing the child, changing the child, and feeding the child, what do we stress? We all try to teach the importance of eye contact, verbalization, hand-

ling, and so forth. Even though we may be simply demonstrating and teaching in an informal sense, we are conveying a set of values about the infant and his need for communication, warmth, affection and play."

* "We seem to be saying then, that some things related to the care of the infant cut across cultural differences and that these things can be considered valid."

* "As an administrator of a program, I assume that 53 years of blackness and association with people have endowed me with something. I am prepared to use my experience in my program. I am not prepared to accept mass ignorance as the democratic process. I am not prepared to perpetuate things that have been drilled into us from generation to generation. I assume there will have to be some unlearning."

* "The role of an administrator is a touchy area. We sometimes trap ourselves by not looking at the broader picture. Every good administrator is going to act on his own values and beliefs and keep his own dignity as an individual. He is going to do his own thinking about what is right for the people for whom he is working. However, if the people and the administrator totally disagree, he should not stay in the program. Nevertheless, most administrators have more information about their program than others. They can talk with the board and with the parents. It is only dangerous if the administrator has total control over the program. This would mean that he had control over the lives of the people he serves. It is important, however, for the administrator to maintain his individuality and convictions in dealing with the program. At the same time, he must also be close enough to the actual service delivery process to realize its impact on the people it serves."

* "I believe we must begin to take a serious look at the research and programming base of the past which was built upon what you might call a 'deficit model.' A recently published book, The Strengths of Black Families, by Robert B. Hill, a young black psychologist, suggests that we begin to look at things in a different light. He explodes some of the myths which researchers and programmers alike have been holding as truths. For instance, he has found that there is a higher motivation among black children to succeed in school than there is among white children. In other words, within our society there are many people who come from a variety of cultural backgrounds. Each of these cultures has strengths. We should attempt a new approach to programming and discard ideas such as: 'We must compensate for the basic weaknesses of these people.' In both research and programming, we should acknowledge the strengths of our various cultural backgrounds."

Parenting

One hundred years ago the average U.S. family had five children. Today the average family has 2.3 children. Therefore, our young people are learning less about the child-rearing process within their own families. Fewer and fewer of them have an opportunity to watch a parent in action or have had any practical experience in assuming responsibility for other children. It seems that society becomes concerned about the parenting skills of adolescents only when they become pregnant. The workshop participants agree that parenting should be a part of the total educational process; that young people should be learning the arts of mothering and fathering at the same time they are learning other skills which will enable them to function in society. The following questions on parenting were among those also discussed:

Does our society now provide youth with adequate preparation for parenthood?

* "I don't think our 20 or 25 year-old women are prepared for the mothering role. None of us who have passed through our educational system as it now stands is prepared to be a mother."

* "Within our school system there is a course in personal and family living given in the twelfth grade and all students are required to take it. Various aspects of health information are also discussed in physical education classes. However, I am sure that you could not assume the students are getting information concerning child development through these courses."

* "Working with young children is one of the most valuable ways of learning. It is also one of the most valuable ways of teaching many different things, not only childrearing principles but respect for the needs of other people. The ideal situation, I think, would be to have child care centers attached to high schools. This would provide a laboratory situation for teaching and for learning about those things that we have discussed. The young mother who is back in high school and the young father who is still in school desperately need this kind of service."

* "I think we must realize we cannot be all things to all people. Although it may be very advantageous for all high school students to have training in child development, if hordes of people were to walk through an infant care center for training purposes, it could be very detrimental to the infants. Any such program should be approached very cautiously. Most of the research literature indicates that having consistent contact with a few adults is very important for the healthy growth and development of the child, particularly during the first two years of life. Even with the most positive motivations, attempting to share the learning experiences with everyone could be damaging to the children in our charge."

* "We have tended through the years to keep to a minimum the number of people who go into the child care center during the day. This applies even to the young mothers. In our child development class period we will take babies out of the nursery into the class only for demonstration purposes."

How can we provide school-age mothers with information about childrearing, and at what point is it most effective?

* "Since we have instituted a day care center we have found that the young mothers respond most positively when they are given a chance to actually see in practice some of the principles we have tried to teach in a classroom situation."

* "Whether or not a program has incorporated group infant care as a service component, it seems critical to the learning process that young mothers have an opportunity to observe and practice some of the childrearing techniques we talk about in the classroom. If they don't have this opportunity, all we teach are words which never become really meaningful."

* "The age of the mother is important. The 13-year-old mother needs special supportive help as well as special parenting information. If she chooses to keep her child, we have to begin where she is and not where we would like her to be. If we are going to meet both the criteria of protecting and helping the infant and developing parenting skills, then we have to accept the fact that a 13-year-old mother is much less equipped to care for her child than an 18- or 19-year-old mother. We must develop programs designed to bring her along in the parental role in the hope that by age 18 she will be well equipped to raise her child."

* "In teaching parenting skills, I haven't found that the age of the infant or the mother is as important as the teacher's sensitivity to the mother's mood. You may have something terribly urgent which you want to share with a mother, an insight that you have had about her in relationship to her baby, but if you try to impart it at a time when she is not receptive, you will completely turn her off. I have to wait it out until I can sense that she is going to be responsive."

* "One of the social workers in our program often has said that three months after the day the baby is born is the day she expects the young mother to come in for counseling. These are the girls who have left the special program and returned to a regular school situation."

* "This seems to be quite common. While I have not really dealt directly with young mothers, I have talked to a number of program directors and one thing they mention quite frequently is that prior to the birth of the baby, the young mother doesn't realize that she is going to be a mother. Then after the baby is born, the young

mother tends to treat the baby as a toy rather than as a person. As the infant continues to grow, however, its demands grow and it requires more of the mother's time. Then real problems begin to arise between the mother and her child. If this problem is common to many young mothers, it should have obvious implications for determining when and what kind of support they need."

* "This is an extremely critical issue. Young mothers must be educated to understand the processes of child growth and development. There is much research indicating that what happens to a child during the first two or three years of life will have tremendous effect on that child's intellectual and emotional capabilities later in life."

* "In our program we have tried several ways of approaching this problem. Most recently we have tried during the prenatal period to emphasize that pregnancy is a tremendous responsibility and the young mother's acceptance of that responsibility begins when she acquires better nutritional habits. We continually stress the young mother's responsibility. The result is that when the baby is born she sees this responsibility in a very new way. Although our program has been operating since 1966, it is only in this past year that girls have identified 'raising the child' as their most difficult task."

* "We're talking about working with the teenage mother to help her assume the parental role. We've talked about a certain amount of training, about having young mothers work in an infant care center and about providing information concerning child development. I am beginning to wonder how we can do all of these things with this girl while she is simultaneously trying to complete her high school education. It seems to me to be critical that courses be accredited by the school system. If they are not, the young mother may simply not have the time for them."

* "I think it is very important for us to recognize the strength of each individual young mother. When a girl comes to our program she must know something about children. We must give her credit for what she does know. We should begin by defining those things she is doing well. We can then begin to work toward helping her develop other skills. I don't think we give our mothers credit for having any common sense at all."

* "We have said we want to work toward improving the young mother's self-concept. To improve self-concept people have to feel that they are succeeding at something; therefore, we cannot begin with the assumption that the young mother knows nothing at all about raising her child."

* "I agree. We should praise her for what she is doing well rather than saying, 'No, that's not right, do it this way.' A large number of training programs have fallen down in this area."

* "We are missing a critical point here. Do the young mothers feel that parenting is satisfying and fun? Do they see as satisfying the various caregiving tasks such as feeding and diapering? If we are going to build good mother-child relationships--and that should be the goal of every program--we had better begin by finding out if the new mother has ever thought of parenting as satisfying."

* "This relates to the issue of competency. If a young mother is not enjoying her experience as a parent, it may be because she doesn't know what to do as a parent. As we work with a young mother we should be willing to sit down and talk about the practical aspects of caring for her child. When she tries one of the things we suggest and it works, her reward becomes that instant feeling--'I can do it!' Enjoyment of parenting is tied in very closely with such feelings of competency."

* "I am not going to argue against what has been said, but I don't believe parenting is that special. I know that may sound harsh. I think the responsibility of pregnancy just intensifies what is already there. If the girl is the oldest sibling of a large family and has cared for children all her life, then she usually takes very good care of her child. If she feels that she is useless and ugly, she feels even more useless and ugly when she is pregnant. If she is very young, the complications of pregnancy only intensify the problems associated with her youth. I think anyone who has a healthy ego and is a healthy person can be a good parent. I don't think that the rudiments of infant care are too difficult to teach. What is difficult to teach is concern about these things and a willingness and ability to learn. I think we must address ourselves to teaching skills and equipping the individual to lead a healthy life. Then, I think, they will be good parents."

* "We seem to have been unable to define the precise qualities of a 'good mother.' On the one hand we are saying that we can teach parenting skills to young mothers by focusing on the rudiments of child care--feeding, diapering, etc. On the other hand, I think we could agree that mothering is at least a rather sustained nurturing role. There is nothing that we know about adolescents in our society which suggests that a 13-year-old girl is capable of immediately assuming such a role. The adolescent's feelings, background, and self-concept will have a great deal to do with her capabilities as a parent and her ability to form a healthy mother-child relationship."

Can we integrate programs designed to support the young mother in her parenting role with vocational programs for those who would like to continue working in the child care field?

* "I don't think we should push the mothers participating in our programs into child care training as a vocation simply because they happen to be in the program."

* "I don't think it is necessary to lure mothers into a program by stating that what they learn from the center will provide a job. The notion that they need to develop some skills to help them do a better job with their children is valuable in and of itself and should be quite sufficient."

* "Currently, paraprofessionals or nursery aides working in licensed day care centers do not make a living wage. The only exception to this are centers supported by federal, state, or local funds. We must be clear about what type of training we are providing. To say we are preparing a young person for a job that pays a living wage would simply not be true. Family day care mothers find themselves in the same sort of situation. While it may seem to the consumer that paying $150 a month for child care is exorbitant, the family day care mother who spends her day in the incredibly tiring job of looking after children, really does not earn enough."

* "My city is now working on a very large master plan to provide a variety of alternate care situations. Although there may not seem to be many jobs available now for nursery training aides, I believe there is going to be a very large demand for people to work in this field. Regardless of setbacks, providing child care services in our country on an extended basis seems to be inevitable."

* "In my area, we have one particular high school that has hired an early childhood development teacher to work with babies in a nursery in the school. The students in this particular course are being paid for the time they are in the center. They also get some credit for taking the course.

"We began with seventh, eighth, and ninth grade students but the interest level of the students in this particular course is so high that now the tenth, eleventh, and twelfth grade students take a similar course. Both boys and girls have shown a high level of interest in connection with the course. We have begun to hold rap sessions concerning sex education and family planning. Students who graduate from the course have been able to find work situations and several have gone on to college specifically to study child development. The course is open to young parents as well as students who have not yet become parents. In addition, the grandparents are forming their own group to study child development."

<u>What is being done to prepare young men for fatherhood either in the public schools or within special programs for adolescent mothers?</u>

* "It seems in general that young fathers, or young men, are completely skipped by our society and even by most of our programs for young mothers. We must find some redirection, and prepare to do some reprogramming in terms of recognizing the role of these young men."

* "I wonder if some of the agencies serving the young mother have the philosophy that the young father doesn't belong there? We have opened up our counseling services to the young father as well as the girl's family and the young father's family. We now have young men coming in, both with the girls and separately, for counseling, and we are finding that they really are concerned. Some are carrying a tremendous amount of guilt and anxiety."

* "In the main, programs are not necessarily supportive to the relevant male in the young mother's life, particularly, no attempt seems to be made to provide any type of education regarding childrearing."

* "I think we have to look at our society and the role that males in general have traditionally held in the childrearing process. In a peculiar sort of way, they have had no defined role. I think we should make a conscious effort to focus on the young father, define his role and include him in our efforts toward assisting young parents."

* "I think we have to view the father as having a very integral role in the emerging young family. This should not depend upon whether the couple is married or not married. We should be looking for ways of supporting those who do have continuing relationships."

* "When we begin to talk about the young fathers we can't generalize. The relationships between young mothers and young fathers vary tremendously. Some marry, some are planning to marry, some young fathers help to support the child, others simply acknowledge paternity, and in some cases paternity is denied or the young mother simply does not want the father of the baby involved in any way."

* "But if there is a continuing relationship, shouldn't programs recognize this? It would seem that such a relationship between a couple has great potential for involving the father and implications for defining program objectives as they relate to young fathers."

* "I feel we should clarify something at this point. Often there is a continuing relationship between the young mother and a boyfriend who is not the father of the baby. Our nursery has recently opened and we have three young men who often come in to play with all of the babies. Two of the young men are not fathers, they are boyfriends. These young men have had a tremendously positive impact upon all the girls in the program by giving them an opportunity to observe that playing with the babies is enjoyable."

* "Our attempt to involve fathers and boyfriends began when they started bringing the mothers and babies to the center. Eventually the young mothers said that they wanted to begin some sort of activity to involve the boys. We have tried to institute an evening monthly meeting with young married couples. However, this has been the weakest part of the program. The idea was to have informational meetings on topics of interest like income tax, health benefits, and so forth. The husbands simply won't come to what they view as an artificial group situation. Also they are a more diverse group in terms of age, interests and education."

* "We want very much to include the fathers. We have set up a group session at night for the fathers and boyfriends. The beginning response has been very favorable. Also, the fathers are welcome to come any time during the day and join in classes. I have quite a few boys in sewing and cooking classes. However, I don't push the issue, they simply know they are welcome."

* "We seem to be very passive about young fathers. We don't expect them to come into the program immediately and learn to care for their child as we do the mothers. When a young mother comes in we become quite active in relating to her. When a young father comes in he is more or less on his own. He asks questions at his own speed and participates at his own speed. This bothers me. Is it a result of the goals we set for our programs, the stereotypes we carry out, or is it a result of the realistic role we can expect of the young father?"

Adoption

One option that should be open to all school-age parents is adoption. The participants discussed various issues involved in the adoptive process, including the pros and cons of biracial adoption, the scarcity of adoptive homes for black babies, and the rights of young fathers.

Are many young mothers giving up their infants for adoption?

* "I have great concern about peer group pressure. It can be quite severe. Often girls who have been given intensive counseling and have made a decision to give their babies up for adoption have changed their minds because of peer group pressure. In developing needed services I wonder if we are giving as much attention as we should to informing each girl about her options. We must be sure that we are offering each girl all the alternatives and perhaps we should be looking for ways to alleviate peer group pressure."

* "I do feel that at times we set the stage for encouraging the girl to keep her baby when otherwise she might not."

* "Practically speaking, if a girl came to me in doubt about wanting to keep her baby, I don't think I could in good conscience counsel the girl to give up her baby. I will feel this way until there are some changes in our system of adoption. The state is subsidizing adoption, and as a result welfare agencies will place a child in almost any kind of family it can find. I could not reassure a girl that her baby would have a good home."

* "If you have some feeling that a girl does not want her baby, allowing her to keep it is detrimental to both her and the child. These are the types of situations that eventually produce child battering. I personally rely on the judgment of the agency responsible for placement."

* "Have any of you found some girls from your programs who were first determined to keep their children are trying to relinquish them when they are two or three years old? The statistics I have seen seem to support the notion that this is an increasing trend."

* "We are finding that some children, primarily the battered child, are coming back to us through protective service agencies. When we investigate we find that the chore of parenthood is simply too much for the mother. Usually the mother and the

child go into some sort of placement arrangement. It is very difficult for agencies to consider severing the relationship between the mother and the child--to orphan the child at age three."

* "Although I have received some complaints from the adoption agencies in my area about this type of situation, upon investigation it appears that there are only one or two cases in which a mother wants to give up her toddler. I am certain it is too early to establish this as a real trend."

* "Another option is temporary placement, which gives the mother the right to take her child into legal custody at a time when she feels able to handle the responsibility. In my state, adoptive parents have to wait a year before becoming the legal guardians. We can also move our girls into a situation of temporary placement which can last from three to five years. Under this arrangement the girl is allowed to see her baby as regularly as she would if the baby were in her own home. This gives the young mother more time to make her final decision. It also gives the agency a chance to examine whether or not the baby is thriving within the foster family."

* "Our real difficulties begin when the young mother chooses not to be the mother in the physical sense but continues to hold the child in some kind of tenuous legal relationship by indicating that someday she wants the child back. In these situations the children may have 10 years of foster care and go through five different foster homes, which is obviously very damaging."

* "I am finding that more and more of the black girls in my program are placing their babies for adoption, or in temporary foster homes. This year there is a definite increase over the past six years in the number of girls choosing this option. I really don't know why the change is taking place."

* "I wonder if this is a result of a change in the attitudes of the girls or a change in the types of institutional programs provided. For years many private maternity homes had unwritten policies concerning the ratio of black girls they would accept. More recently, as maternity homes are closing down for lack of clients, it seems they are admitting any girl who is willing to relinquish her baby."

* "I don't think that we can document this, but in five years we should be able to determine if the black girl's attitude is changing or agencies are changing their policies. I do know that at one time public agencies would not take a black child for adoption unless adoptive parents were available. One thing that is happening--we are offering our girls more options. Now we thoroughly discuss whether or not the girl really wants to keep her child."

* "I am aware that there are places in this country where people wait forever to adopt babies. However, in my local community a black baby, or a baby of mixed racial origin has little or no chance of placement. Welfare agencies in our area are looking desperately for people to adopt these children without success. Many of these children will have to go through a lifetime of foster homes or various types of group care."

* "We bring in a black social worker from an adoption agency to speak to our girls twice a year. The interesting thing is that the black girls in the program resent the fact that a black person would even be working in an adoption agency."

What about biracial adoption?

* "I was at a Child Welfare League conference last year and attended a discussion concerning biracial adoption. The black social worker at the conference felt very strongly that it had to be scrutinized with the greatest of care. The whole notion of passing on a cultural heritage was reviewed. She expressed fear that a black child adopted into a white home would miss this enrichment and grow up without a positive self-concept."

* "A black social workers' group met recently and issued a strong statement against white parents adopting black children, or even boarding black children in white homes. I am not sure that I agree. All of us are aware that we are not a pure racial strain. I think that it is important to give the same kind of help to all children. Is it a better solution that a child grow up in a foster home without real relatives or strong ties? There are white couples who can do a good job. There are excellent foster homes with white parents. I think that such a resolution really is not taking into account the needs of the infant."

* "There is a National Council on Adoptable Children working to change state laws that insist upon the perfect match of adoptive parent and child."

* "The experience I have had with biracial adoption indicates that it is a faddish thing. I can look at it from the materialistic point of view in terms of things a child is offered in a 'good home.' I have a tendency to support it at that level. However, at a much deeper level I have very strong feelings against it. The black child today has so many frustrations. From a cultural heritage standpoint, biracial adoption can only add an additional frustration."

* "We have locked the discussion into an issue between the black and white members of our society. Many minority groups, particularly Asians and Indians are experiencing an increasing sense of militancy about their cultural identity. I happen to have a number of Asian girls in my program and the same issues, the same questions are being raised concerning biracial adoption."

* "I think we are making too much of a socially imposed factor such as culture. Placement is being sought for many children of mixed racial origin. It is a mistake to say that this child is of one race and therefore must be in with one kind of family. We need to be more open."

* "We have to be practical and recognize much of what impinges upon the minority child, Asian, Indian or black. Ideally, we can sit here and say that there are no 'pure' racial strains. But we also know about the hurt experienced as that child grows,

particularly into early adolescence when social identification begins. Through identification with his cultural background, the adolescent begins to move into a freer social group. The possibility that a white child could be rejected because his parents are black, or a black child because his parents are white can't be ignored. There are all kinds of things that will happen within that family constellation at each level of development brought about by what society unfailingly does to a child who looks, speaks or does something different."

What about the rights of the young father as an adoptive parent?

* "A recent court decision in Illinois, the Stanley decision, has some bearing on this issue. In this particular instance, the couple had lived together on and off for 14 years and therefore, in some states, they would have been considered married under common law. The mother died and the father, working through the courts, obtained legal custody of the three children. This is the first case supporting the parental rights of a father. This legal precedent may have a tremendous effect in the future on the role of the father in the programs you operate."

* "The rights of the father have also come up in Michigan. In this particular instance, the couple was quite young; the girl's parents would not permit her to keep her baby at home, although the couple did have long-range plans for marriage. Since the couple did not want to lose the baby, they took the case to court and asked that the father be permitted to adopt the baby. The local judge decided that the father had a right to request adoption. This was based on the fact that, although both natural parents were very young, the boy came from a stable home; his parents were willing to have the child in their home, and there was an ongoing relationship between the natural parents. However, the social service agency involved in this case took it to the Supreme Court. There was quite a bit of publicity. The Supreme Court decision supported the view that if the mother does not wish to keep her child, the father has the right to legally adopt the child before consideration is given to a person less directly related to the child. I think that there is a trend now towards recognizing the rights of the unmarried father to guardianship."

* "I think that this could become a very complex and confusing issue in the future. I have a girl in my program who wants to give her baby up for adoption, but the father of the baby is violently opposed. This has caused a tremendous amount of turmoil."

* "I feel that we must take a very careful look at this issue, in terms of what is best for the mother, the father and the child. I can envision many cases of turmoil and conflict. We had better be prepared to deal with the issue."

PARENTS SEARCH FOR QUALITY IN PROGRAMS FOR INFANTS

by Mary Elizabeth Keister, Ph.D.

Coordinator of Early Childhood Programs, University of North Carolina at Greensboro, Dr. Keister formerly served as Project Director of the Demonstration Project in Group Care of Infants sponsored by the Children's Bureau of the U.S. Department of Health, Education, and Welfare and the Appalachian Regional Commission.

Mothers who must seek gainful employment, or who must go to school, or who feel they need help with the burdens of child care are likely to select too casually the facilities where they will leave their babies for the day. Professionals in the field of child care are inclined to urge that no baby under the age of two be taken outside his own home for all-day care and especially not into a group with other children.

Somewhere between these two approaches to the care of very young children lie the essential issues that permeate the field of infant-toddler care. Between unplanned, nonchalant arrangements for child care and anxious warnings of detriment and danger there is much to be examined.

The stance of the professional derives in large measure from acceptance of the point of view of a report published by the World Health Organization in the early 1950's. It might be fair to state that no report in recent years has had a more incisive effect on psychiatric theory, on social work practice, on child-caring institutions, and on legislation than has the classic monograph prepared by Dr. John Bowlby, Maternal Care and Mental Health. Dr. Bowlby summarized the results of a variety of studies carried out in many parts of the world and drew the conclusion that what a baby needs most is a mother's care. His report startled and frightened many as he described irreversible damage to the psychic development of children reared without a mother's love and concern.

In the years since that report appeared, a second look has been taken at these conclusions. Ten years after publication of the Bowlby monograph, the World Health

Organization published a second report, Maternal Deprivation--A Reassessment of its Effects. The literature of child development research theory began to analyze the essential characteristics of a proper environment for infant development. The moot question then became: can these essentials be provided outside the infant's home during the daytime by a person other than his own mother?

All mothers want the best for their babies and would not knowingly choose the second rate in preference to first quality. But what is quality in an arrangement for infant care? And how is a parent to recognize it when it is found?

The following points tell how to identify a good program for babies and their families. They try to answer two questions: What is quality in an arrangement for infant care? How is a parent to recognize it when it is found?

In the search for quality infant care in a group setting look for:

A program that expects a high degree of involvement with the baby's parents and home and family, that sees itself as a supplement to parental care

A program that tries to ease the child's separation from home and parents by building some familiar bridges between the home and the out-of-home facility for daily care

A program that gives attention to health and safety, that says physical well-being is important all through the day

A program that includes a variety of workable plans for occasions when the baby becomes sick

A program that involves a relatively small number of familiar adults who have continuing contact with the baby and that involves one adult with a relatively small number of babies

An arrangement that assigns importance to playtime and gives high marks to adults who enjoy playing with babies

A program in which a baby is talked to at frequent intervals and when appropriate

A program that provides richness in the surroundings, a variety of interesting and challenging things to do, new experiences and time to savor them

A situation that gives the baby or toddler freedom to explore, to satisfy curiosity, to use emerging skills, to master new skills

Days that provide for some time alone and for "moments of peace"

A life that sets limits and boundaries and that offers the child help and support in coping with frustrating experiences

A balance of properties in the surrounding atmosphere to achieve: more order and consistency than chaos, more color and action than blandness, and more encouragement and praise than scolding and criticism

A program where the adults show respect for the individuality of each child and communicate to him a sense of worth, a sense of being a person, of having a special place in his world

QUALITY CARE FOR INFANTS

by J. Ronald Lally, Ed. D.

As Associate Professor of Child Development and Education at Syracuse University, Dr. Lally is Director of the Syracuse University Children's Center. He is co-author, with Alice Honig, of a "first-of-its-kind" book, Infant Caregiving: A Design for Training, written to be used for training teachers of 0 to 3-year-old infants.

In discussing quality care for infants, there are four major areas which I will address. The first is the setting or style in which an infant program, whether it be a family day care or group day care program, should be housed. Secondly, I would like to speak about the emotional needs of infants as the base for any kind of programming. Third, I would like to discuss some general child development phenomena which are particularly interesting to the children's parents and grandparents. Finally, I would like to spend the majority of the time discussing cognitive development. This may be particularly relevant since the setting and the whole emotional climate of any program directly affects whether you succeed or fail in fostering cognitive development. As a final qualification, I am going to focus on the younger child, the infant between 0 and 18 months, although our program at Syracuse does include children up to three years of age.

The Setting

In considering the setting of any care arrangement the most important aspect, especially when we are caring for infants, is that we need to keep small numbers of them together. For example, we don't want to set up a large room with 36 infants in it. Infants, especially in this age group, have great difficulty handling large numbers of people. I would recommend approximately eight infants to a room with definite assignments of a child to a caregiver. It is extremely important that every child be assigned to a caregiver. Rather than having a room in which you have eight children with two caregivers generally responsible, you should assign four of the children to each of the caregivers.

Obviously, the caregivers have to work together to help each other with the many tasks involved. However, from the start a parent knows and the infant knows or begins to get the feeling, that he is attached to a particular caregiver. Further, the director of the program knows that a caregiver is responsible for these particular children. The caregiver is able to follow the development of her children. She is the person responsible for checking with the nurse if something is wrong with the child. She writes notes home to the parents or confers with them when they bring the children to the center and take them home. In short, she is responsible.

When caring for children in the 0 to 18-month-old group, I would recommend consistent volunteer or back-up help. Note that I say consistent. If you are using volunteers, usually a blessing, see that they come to the center on a consistent schedule. A child at this very early age needs constancy in the people surrounding him. For example, it is a very confusing thing for an infant if 20 students act as volunteers and a different one comes in each day. It is preferable to have one person coming in every Thursday, and assisting with the care of the same children. If you do have irregularly scheduled volunteers, assign them tasks which do not involve actual care of the infants.

Finally, I would suggest a free, but not a limitless, kind of environment. Using the example of eight infants in a room, this size room might be very good. You need walls, a confined space, a defined environment for the infant to "get into." I would prefer to be able to speak about all of the things related to setting in greater detail. All of them are negotiable and certainly you can adapt them as your program needs dictate. For example, there are ways to change the spatial climate in a room by manipulation of furniture, use of room dividers and other things. I am not trying to be dogmatic, but I do recommend that small numbers of infants be kept together, that they be identified with a particular adult and that the environment not be limitless.

Emotional Needs

Before discussing directly the emotional needs of the infants, it seems important to address the general philosophy which should be inherent in any program designed to deliver alternate care services. The philosophy of the Syracuse Center is that we are the support of, rather than a substitute for the parents. Most of the literature related to child development tells us that the child imitates and identifies with the people he loves most in infancy. In the vast majority of cases, these people are the parents. Therefore, if a program attempts to substitute for the parent, problems will undoubtedly arise. I am not addressing the question, which has been raised by many, about a loss of attachment because of separation anxiety if an infant is placed in a temporary alternate daily care setting. In the case of group or family day care, the distinction is that it is not a permanent separation, it is a temporary separation. The child soon learns that every night he is going back to his parents and family. However, the important distinction to make is that the caregiver is the support to the parent. The difference lies in attitude. Does the caregiver feel that "this poor little child has such a miserable existence at home that I am going to compensate" or does the caregiver feel that "I can facilitate the interaction and bond between this mother and child by allowing the mother to see some of the things we think are good for her child." These two attitudes are quite different. In other words, if you give without letting the person you are giving to have a significant part in the action, you

are not really giving, you are taking. You are taking the dignity of those people you are giving to. Programs must be modeled to support the parents.

With the support of the parents, we still want to build a security battery for this infant. Although it is impossible to separate cognitive development from emotional development, when we talk about them we always do make that distinction. The child will not learn in an environment which is strange, hostile, or uncaring. Therefore, we must provide him with adults who have a good feeling about him. In this first period of life we must establish a basic feeling of trust between adult and child. Your first job is to establish this basic trust. It is essential for everything else you want to do. It is essential for the provision of quality care.

As I mentioned earlier, assignment of caregivers to specific children is essential. What happens is that the infant begins to perceive that this person is his caregiver and that a variety of things are happening in his immediate environment. As the infant begins to grow and learn, he ventures out from this warm secure battery of emotion that he has established with his caregiver. If he ventures too far and is threatened by the strangeness of the world, he knows that he can run back to a caring person for reassurance and a "revving up" for more exploration into the world. Without this feeling of basic trust in an adult the child is not going to venture out into the world. He is not going to explore the world which is a very risky and unloving place. All of the things which I speak about later are based on this establishment of basic trust between caregiver and child.

Developmental Phenomena

This particular topic has caused numbers of problems for parents, grandparents, other family members and finally for programs attempting to serve families. The best way to characterize it is that parents and family members do not have a basic understanding of child development phenomena which all children experience. Basically, adults tend to attribute adult reasoning to the child and therefore assign causes for a child's actions which simply don't exist. Three examples of this misunderstanding should help to delineate the problem.

The first is the "fear of strangers" phenomenon. Somewhere between the ages of 6 and 12 months an infant becomes afraid of strangers. What is happening here? Many of you have observed that at the beginning of life an infant will bring his arm or another part of his body to his mouth and will subsequently bite the arm or hand. The infant then cries. Yet, he will repeat the action, bringing, shall we say, his arm to his mouth, biting and then crying. The infant does not realize that he is hurting himself because he has no understanding of self. This is, of course, a very young infant that has not become de-centered enough even to have this identification. As the infant grows through the first six months of life, he gradually begins to differentiate himself from others--"the me and the not me" in the most basic terms. Those things that are "me" and those things that are "not me" become differentiated. Further, the infant becomes accustomed to some adults, particularly the principal caregiver, usually the mother, as well as others around the house. Fear of strangers between 6 and 12 months is evidence that the infant can discriminate between those adults usually around him and those not usually around him.

Let us then take a hypothetical situation. Grandmother lives nearby. She comes once a week to visit. During the first six months of the infant's life, grandmother's visits were happy occasions. She picked the baby up, held him, played with him and he responded with a smile or gurgle. At seven months, grandmother comes to visit and play with the baby and suddenly the baby begins to cry. This happens several weeks in a row and finally grandmother says to the mother, "You're turning the child against me. What are you doing to make the child like this? He doesn't love me anymore. You're spoiling the child. He can only relate to you and not with anyone else." Thus, familial strife. Unnecessary strife.

What has actually happened is a part of cognitive development. The infant is now capable of differentiating from others the warm loving person, the principal caregiver, in whom he has trust. He grows out of this as he becomes more sophisticated. He does not discard his trust of his parents but he does become able to make more subtle differentiations between friends and foes.

As a second example, let us consider the 12-month-old infant who is beginning to experiment with spatial relationships, means-ends, and relationships between cause and effect. Again a hypothetical situation. The infant is sitting in a high chair. He has a spoon which he promptly drops on the floor. Mother picks up the spoon, gives him another which he again promptly drops on the floor. Mother decides to give him some blocks to amuse him, six to be exact. He drops all six blocks. Some he drops over there, some he throws over there and over here. Mother thinks, "This child is trying to drive me crazy. Every time that I try to feed him he takes the spoon and the food and throws it on the floor. He is going to learn that when he is being fed there are right and wrong things to do."

What the child is doing is experimenting with spatial relationships. He is experimenting with release and no release. He is trying out all of these new schemes of behaving in the world. Mother is looking at the action through her adult eyes and assuming an intent not present in the infant.

Finally, although I do not like to pin chronological dates on these kinds of things, around 18 or 20 months of age we begin to observe negativism. This can best be characterized as the "no, no" stage. The child and the parent run into their first major confrontations of will. What the child is saying, as we look back at fear of strangers in a more sophisticated way is "Hey, look at me, I'm separate from you." Around this time the child will say no, and do the action for you anyway. Nevertheless, the child is moving along the dependence-independence continuum toward independence. Many times parents or caregivers react with, "Here it is, I knew it was coming. This is the final test of wills, of who is in control. I am in control and I am going to require 100% obedience." What the child needs most at this time is for you to require 80% obedience. For example, if you want the child to take his toys to his room or to the other part of the building he may take only three quarters of them back. Or he may put them just inside the door. He is demonstrating his sense of independence. You need to realize that this is a developmental phenomenon.

Others who have been doing research on this particular phenomenon have found that between the ages of 15 and 18 months, the number of times that the parent says "no" to the child increases approximately 300%. This is a result of the fact that the child is now more mobile, active, verbal and generally into everything. Thus, the parents use of the negative increases. If you accept this hypothesis, the child's use of "no" could be a result of imitation. I personally feel that the child is demonstrating his increasing sense of independence. Whatever the cause, this particular phenomenon is a part of the developmental process. Parents and caregivers need to deal with children as children, not as adults. I am not saying that children need be allowed to do everything. Limits must be set. However, it is better to understand what is happening from the child's view rather than the adult's view and then go about setting the necessary limits.

Cognitive Development

There are seven major areas of cognitive development. I will give one or two examples of activities in each area. All of the activities are of a sensory-motor nature. According to Jean Piaget, the well-known Swiss child development expert, sensory-motor learning is the process that goes on through the first 18 to 24 months of life. It is very difficult for us as adults to think about sensory-motor functioning. The best example that I can give you is Helen Keller. Helen Keller was asked if she could remember how she thought before she had language. She said that ice cream to her was an itch across the palm of her hand. As they pursued that with her, she said that whenever she wanted ice cream she had to turn the crank on the ice cream maker in order to make the ice cream and then she could have it. Now, what she was describing was sensory-motor thought. As adults, we think that our thinking occurs somewhere within our heads, but the very young child's thoughts are in his senses--out in his body. He has no abstract cognition. An infant begins the growth toward abstract thought by going through manipulations of his body, hands, arms, legs, etc. He doesn't have the abstract symbols that we have. His symbols are motoric and sense symbols. That is the way that he thinks.

Before reviewing the seven areas of cognitive development, there are some general principles which will help teachers who are trying to get children to become involved in learning something new. The first thing is to isolate that particular concept which you are trying to teach. For example, probably one of the most confusing toys that a very young child can have is a plastic ring stack with rings that are different sizes, different shapes and different colors. We assume that he is learning something from that toy, although I am not sure what he could be learning. A more appropriate toy, if we want to teach something about size, is one that isolates size. In other words, use materials which are all the same color, all the same shape but varying in size. Then the child is forced to focus on that particular concept that you are trying to teach. Another example particularly appropriate for the child from 18 months to 3 years of age, during which time vision is an overpowering sense, is to find ways of helping the child use different senses. You must somehow find ingenious ways to isolate vision in order to give the child tactile, auditory and olfactory experiences on which he can focus. Put objects in a box and have the child feel and identify them. If the child will permit it, use a blindfold. If he is going to do some smelling, have him put his hands over his eyes. In sum, isolation is a very good tool in sensory and conceptual work with very young children. A lot of useless information more often than not is confusing to the child.

A second thing that you need to know if you are going to work with infants is that you can not plan in advance a program of activities that you intend to follow. For example, a mother involved in a home intervention project said to the home visitor, " We had to stay up all last night; I knew you were coming and I hadn't worked out the activities all week so we had a crash course."

You need to react to the kind of thing the child is doing. You can't prescribe beforehand. You can bring in the materials--and I will be giving you some examples of some of the areas in which you can work--but you have to "go with the child." This whole concept has been crystallized by J. McV. Hunt into something that he calls "the problem of the match." The problem of the match is finding that activity which is not too difficult for the child and therefore, boring or frustrating, and not too easy for the child and therefore, boring. You must find a particular activity which is just at the appropriate developmental level so that the child will have some difficulty with it, but nevertheless will be able to succeed. It is impossible to pick out that kind of activity the day before. You have to focus on the child and work with the child until you can find the appropriate activity.

In addition to reacting to what the child is doing, you must guard against the notion of the student as passive and the teacher as active. I have found that it is very difficult to train a teacher to be less verbal. When you are working with a child you will find that you want to fill up the voids of silence with explanation. When you do this, you are not giving the child a chance to respond. You may set the situation up properly, but not pause long enough to give the child the idea that you expect him to respond, let alone the time to think about the particular task. Try not to move the materials around and complicate the situation by verbiage until you are absolutely sure that the child is not going to respond.

Another important thing is what Piaget calls horizontal décalage. If you are trying to teach a child about means-ends relationships by showing him how to get a favorite toy that is out of reach by using a stick, you can not assume that he has the concept of means-ends relationships once he accomplishes this particular task. He needs to have experiences with pulling strings to get other things, using his foot to reach something he can't reach with his hands. He needs to have many experiences which will broaden his base of understanding; then gradually he will begin to understand the concept. You can not equate success on one activity with concept understanding. So expand, give lots of different materials and activities for the child in the same areas and at the same levels.

Now for the different areas. The first, and most basic of course, is prehension or grasping skills. All that is necessary is to give the child in his early environment, in his crib or while he is on the floor, things which will alter his grasp. You know that when you tickle the hand of an infant you get an automatic grasping mechanism. According to Piaget this is one of the basic schemes that people come into the world with. Some of the other schemes that people come into the world with are seeing as opposed to looking, hearing as opposed to listening, sucking, and, some researchers say, crying. Reseachers vary in the number of basic schemes they attribute to the

newborn, but we do know that there are some basic things that the child comes into the world with. Then he accommodates to the world and changes his ways of behaving as he grows. In relation to grasping, by simply giving the child a variety of objects to grasp, we are altering his original grasping response--with each new object the child must learn a new way of grasping. From here we move toward coordination of grasp, looking and grasping and looking and grasping and sucking. This is a basic part of the evolution of the learning process. All you have to do at the beginning of life is to give infants different things in their environment and they will run through their basic schemes of acting.

The second area would be the area of object permanence. This is probably the most well known area. By object permanence we mean that we are trying to help the infant find out that objects do not disappear when they go out of signt. There are many activities which you can do in relation to object permanence but the basic objective is to help the infant begin to understand that he is permanent, his mother is permanent and objects are permanent. As examples of some of these activities: take a favorite toy and in front of the infant place it under a cloth, hide toys under a table, play peek-a-boo. The activities can get as complex as having four screens and putting your hand under each screen concealing the object that you are hiding. Leave the object under the screens and have the infant search through the various screens to find the object.

A third area which I mentioned previously, is that of means-ends relationships. These activities are designed to help the infant use tools to extend his action on the environment. Gradually all infants learn that they can use a tool, that they can extend their bodies and their potency in the world. The infant becomes aware that he can extend his capabilities by combining himself with objects or other people. To reiterate some specific tasks: using a stick to obtain a favorite toy that is out of reach; using a string to pull a toy nearer.

The fourth area is that of cause and effect relationships. The distinction between means-ends relationships and cause-and-effect relationships is somewhat less clear than the distinctions between the other areas. In working with cause and effect, we are trying to help the infant learn that there is something within an object which will cause it to do something, or that by acting on an object something will happen. By means-ends, for example, you combine yourself and a hammer in order to drive a nail. By cause and effect, for example, you are trying to understand why a car is moving. Activities which will help infants learn the concept of cause and effect are numerous. You could set up a situation in which a child pushes a ball which hits a stick that falls into water and creates a splash. Using a wind-up toy is another excellent means of demonstrating cause and effect. Wind up a music box and hand it to the child. The child will play with it for awhile, like the music, and then it stops. Usually a very young child's response will be to cry. As he gets a bit older he will hand it back to the person who caused it. Later he will begin to examine the music box to find out what was causing the sound. Still older, he will be able to act on the results of his examination and activate the box again. These cause and effect situations are extremely important experiences to give young children during the first two years of life.

The fifth area is classification. Here we help the infant develop new schemes, new plans of understanding in relation to objects. All that is necessary is to give the child soft things, sticky things, pleasant things, fuzzy things, fast things, slow things, big things, small things. Put the thing in front of the child and let him run through his schema. You will see that he will put it in his mouth, rub it on his cheek, crumple it, hand it to somebody. In short, he tries all of the things that he knows. This is his way of learning about things. He runs through all of those actions which help him to categorize aluminum foil as opposed to scotch tape.

The sixth area is spatial relations. As an obvious example, if an infant is looking at something which is moving away from him he really doesn't know that it is the same object moving farther away. It is a good possibility to the infant that the object is simply getting smaller. As an example, on a recent field trip to an airport one of the children in the 15 to 36 month-old group said clearly that he did not want to go. When they got to the airport the child began to cry. The teacher said, "Oh, it's not going to be that bad or noisy. We'll be with you and the plane isn't going to frighten you." The child responded, "Yeah, but I can't fit into it. It's only this big." He indicated a very small object. Every plane he had ever seen before was way up in the sky and was only about that big.

Another type of experience comes as the child learns to deal with spatial relationships. In your centers set up cul de sacs, little tunnels, tunnels that are large at one end and smaller at the other so that when a child crawls in he gets stuck. What the child is learning in this latter example is how to judge his body in relationship to other objects in his environment. Roll a ball under a table and have a child crawl under the table to retrieve it. Give the child the experience of having to go around barriers to retrieve toys rather than stopping at the barrier and crying.

The last area, and probably the most important, is the development of imitation. Not only do children identify and imitate their parents, they do this with all adults. We can break imitation into two rough categories. The first would be vocal imitation. You are aware that you can get an infant to imitate your babble. One of the first things that an infant will say is "ah goo." Respond to him, tickle his stomach and say "ah goo" back. Then the important thing is to remain quiet enough to allow the child to respond back to you. This is the beginning of a very basic communication process. Non-vocal imitations are all of those other types of imitation which occur in the child's environment. Again, these can be broken into two categories: visible and invisible imitation. A visible imitation would be, for example, the game of patty cake. It is visible because the infant can see your hands and he can see his hands and he can watch what is happening. An invisible imitation would be doing something that you do which he can not see himself doing. For example, you pull your ear, and the infant imitates by pulling his ear. Invisible imitations are a little more complex than visible imitations. One of the reasons that children are so fascinated by mirrors is that they have an opportunity to see some of those things that they have never seen before. After the infant realizes "that's me," it is extremely useful to have mirrors around. You can use them for visual displacements, moving things behind the child.

These are the most important areas in which to develop cognitive activities if you intend to work with infants. There are many excellent resources which specifically outline such activities and sequences of activities. Certainly the Office of Child Development and the Consortium can provide you with reference lists.

I would like to conclude with two thoughts. The first is that some of these activities sound very structured. I hope that you will be c[illegible]o have your caregivers integrate these kinds of activities into the normal day-to-day goings-on in a program rather than to set up a class. This is especially important for programs that work with parents on an out-reach basis or in a center. You should avoid saying, "We are going to have an hour and a half child development class and we will have our formal education for our infants at this time." What you should do is have your parents and teachers involved in the informal learning process that goes on all of the time that the infant is awake. It should become a part of a life style rather than a segmented part of life which you forget about after the hour and a half is over.

The second and concluding point I want to emphasize is the importance of meeting the emotional needs of the infant. Without the warmth, reinforcement, kindness and security that you give to the child he will not be able to explore and learn about his world.

Meeting the Needs of Infants of Adolescent Parents

On the second day of both workshops, participants discussed the issues surrounding services to infants of adolescent parents. As has been previously noted, most of the participants were operating or planning to operate group infant care centers. Most of the discussion, therefore, centered around group care of infants: what constitutes quality group care, and how quality care can be given within the various program structures.

A recurring theme of the discussion involved the differences in programming required when serving both young mothers and their infants. The speakers outlined the basic requirements for quality care of infants in groups (pp.28-39). The participants then discussed the specialized needs of adolescent mothers and their babies and how these needs influence the type of program provided. Since most of the group care facilities began as adjuncts to existing programs for pregnant girls, program planners were forced to operate under existing fiscal and agency restraints. Thus, questions concerning the setting for an infant care center, health requirements, and staffing were among the first topics discussed.

The Setting

An important aspect of quality infant care is the setting in which it takes place. The following issues were considered:

How can programs best implement the principles of quality care for infants?

* "I am particularly concerned about the issue of continuity of care for infants. Although we do assign caregivers to specific children, our principal problem is that the infants are in the center for a very short time -- three to six months at the most. The principal thrust of our program is to provide continued education to the pregnant girl until she can return to her regular school at a convenient semester break. Any impact that we can have through our nursery may be very short-lasting, both in terms of helping the young mother assume her role as a parent and in terms of providing an environment conducive to the healthy growth and development of the child."

* "We must plan for continuity of care. If we stop providing services at age three months or six months, we are creating a variety of problems. If we cannot find ways to continue delivery of services, which would be the optimal solution, then we must find ways to aid the transfer of the mother and child to other services. Again, this raises the problem of the infant's need for consistency in terms of the adults he relates to."

* "We really don't know whether placing a baby in a nursery at four weeks of age will be damaging. We can lessen the potential danger by providing times during the day for the mother to come into the nursery and care for her child, thereby reinforcing the mother-infant bond. If we are to promote quality early infant care, the center should be located near the program for young mothers or the regular high school, and it should continue until the infant is at least one year old, and optimally, until the infant is two."

Is there an ideal infant-caregiver ratio?

* "I am concerned about the ratio of five infants for each caregiver. I realize that having the five infants in a separate room with the caregiver makes a difference, particularly since many of us must keep 15 to 18 infants in a large room. But it seems to me that a lower ratio would be preferable."

* "Dr. Keister has said that she started with a ratio of one to three and did not move to the higher ratio of one to five until her staff had experience and training, and her research had demonstrated that the infants were not being harmed by group care. Also, in contrast to some programs where infants are admitted at a very early age, the minimum age at which a child is admitted is two-and-a-half to three months."

* "Dr. Lally's center has a ratio of four infants for each caregiver. However, he mentioned that his infants entered the center at six months of age and were kept in smaller rooms in groups of eight. If you are working in one large room and also trying to work with the young parents teaching childrearing skills, a ratio of three to one is minimal."

* "We also have a large room. Our maximum capacity is 16 infants. I previously had an opportunity to work in smaller rooms with smaller groups. There is a tremendous difference in working in a large room. There is much more noise. Adults tend to relate to one another rather than to the children. Even with a staff of five women, the interaction patterns between staff and children are entirely different. Occasionally you end up with five adults relating to one child."

* "There are some imaginative ways of arranging space modules within single rooms. Nevertheless, it is more difficult to have everyone in one room regardless of the amount of space or the manner in which it is partitioned."

Is there a possibility that infants may become overstimulated in a group care setting?

* "I am quite concerned about overstimulation of very small infants, two weeks to four months of age, who are in a large room with 14 or 15 other children. With adults talking and toddlers walking, crawling and babbling, I am sometimes afraid that the infants don't get enough sleep and become overstimulated. I realize that infants vary in the amount of noise and stimulation they need, but we may be creating a damaging environment for some infants."

* "An additional problem in our program is that the girls are not permitted to come to the nursery until classes have finished at noon. The result is that at noon all the girls head for the nursery -- not just the mothers, but the pregnant girls as well. There is a good deal of handling of the infants. Are we risking overstimulation in having a situation where four girls are leaning over one crib playing with one baby or babies are being exchanged for the girls to play with and hold?"

* "I think we have to be aware of the individual needs of all children. If we are dealing with very young infants, we know that some need a relatively restful and quiet environment while others want and need quite a bit of stimulation. In operating our programs, we should take a careful look at the needs of very young infants and design the center to meet those needs."

Health

To facilitate discussion of health care delivery in programs for adolescent mothers and their infants, the various options available to program planners in structuring the health care component were outlined. Option one provides for care within the center by having a pediatrician or pediatric nurse on the staff full-time as well as on call during the hours the center is not open. In option two, the program depends on a health facility at some distance from the center where total care is available to the children at all times. Option three makes every parent responsible for obtaining the appropriate health care for her child -- the question here is how much responsibility the center has for helping the parent find adequate health care. Option four is a preventive program. It is the one currently followed in most programs caring for children older than three. A pediatrician is paid by the center or assigned by the health department to visit, usually twice

a month, with a public health nurse. He is responsible, initially, for examining the children, and for administering immunization shots and making referrals if the mother wishes. He also counsels the staff. This option can be categorized as "health surveillance" as distinct from health care.

Since we are serving infants of adolescent parents, how should the health component be structured?

* "In relation to option number one, I am opposed to the center providing the primary health care, especially for adolescent mothers. After our mothers leave the program, they are going to have to learn how to use the services of the community, how to determine what good health care is, how to find a pediatrician, and how to judge his or her competence. If we provide primary health care within the center they are not going to learn those skills which they will need for the rest of their lives."

* "I disagree, I feel that all health services should be tied directly to the program. There should be a full-time nurse in the center and a pediatrician on call or visiting a certain number of hours each day. In addition, the young mother should receive complete prenatal and postnatal care."

* " We have to be realistic. If we are going to have an infant care center for teenage parents that incorporates primary health care, we are going to price ourselves out of existence. I suppose our program falls under option number four. We have readily available emergency service, which is a necessity in any setting involving children. However, there are health care services available within the community. We have a staff member assigned to help the young mothers use these services. I feel it is our responsibility to recognize any problem situations which arise regarding the health of the infant and then help the parent to find the appropriate health care."

* "While we are defining programs, ours falls into category number two and we feel that it is quite successful. We are linked to a children and youth project which will provide services to all of our mothers. If they wish to use the service, extensive records of the infants' and the mothers' health are kept at least until the mother is 19 years old. Our pediatric nurse maintains the closest possible liaison with the project. In addition, a pediatrician from the project is assigned to visit our infant center twice a month."

What special measures should be considered in delivering health care to the infants of adolescent mothers?

* "We are certain to find difficulties among children born to very young mothers. The percentage of these difficulties is quite small but statistically significant. The 11- or 12-year-old mother runs a relatively high risk of bearing an infant with a variety of health problems, while a 17- or 18-year-old girl who has good dietary habits and comes from a healthy social environment probably will bear a healthy infant."

* "This should make a difference in the type of programming we plan. We should be more sensitive to possible abnormalities among our infants. In addition to the mother's age, we must also take into consideration her socio-economic status. Mothers of low socio-economic status have a higher incidence of bearing mentally retarded children. This factor is probably due to poor prenatal nutrition."

* "Isn't poor prenatal nutrition one of the most basic problems that our programs originally set out to correct? Our county, which has had a program for pregnant girls for a number of years, has found statistically that the numbers of low-birth-weight babies born to mothers in the program has been significantly reduced by providing prenatal services. We have been able to make a real impact on this problem. In an adjacent county, where there is no special program, the number of low-birth-weight babies born to adolescent mothers is similar to the national statistics. Without comprehensive prenatal care we may indeed have to tailor the health care within programs for infants or adolescents in a special way. However, with proper prenatal care these difficulties should be reduced."

* "Proper nutrition for the infant is also very important. We emphasize the nutritional needs of the child to every mother and hope that she will follow our lead. However, a very real question concerns the total economic status of the family which, of course, affects their ability to provide the proper food for the child. The family simply may not be able to provide the proper diet. I think it is our responsibility to identify such cases and then either supplement the infant's diet or coordinate our efforts with some agency that will help the family."

* "I think we should be more specific. We are all providing services for school-age mothers. Young mothers need constant help in dealing with the health of their children. I have found it necessary to keep complete records of the dates that each child is supposed to go to the well-baby clinic. Further, I must constantly remind the young mothers about clinic appointments."

* "Young mothers need help and training. Many of them simply cannot distinguish between when a baby is crying out of hunger or crying out of pain. A fifteen-year-old mother brought her baby to our center one morning complaining that the child had cried all night. We found the baby had a broken leg, but the mother obviously had not recognized the problem."

Should we admit ill children to our centers?

* "In considering health policies in our centers, we must also address ourselves to the issue of admitting minimally ill children. The American Academy of Pediatrics recommends that minimally ill children should not be excluded from a day care center. Yet, several other organizations, and a number of centers, do exclude ill children."

* "I think we should realize that a mother at home does not have to be a nurse or a doctor to take care of a sick child. If a competent mother can take care of a

sick child, then a good caregiver can do the same. Of course, necessary medical help, at whatever level, should be provided. But, unless a child should be in a hospital, he can be taken care of as well in a day care center as at home. All of our caregivers should be trained to take care of sick children. Obviously, some sort of an isolation room or quiet place for sick children should be provided and they should be given the same careful attention they would get at home. We lose sight of the fact that what a sick child needs is loving care not a sterile environment."

* "Ninety-seven percent of the children served in our center are there every day because the young parents cannot afford for them to be elsewhere. Further, I see no reason not to admit moderately ill babies because whatever has caused the illness has been with the child for some time and the other infants in the center have already been exposed."

* "If we have too rigorous a policy on illness, mothers who want to work or continue in school will opt for some kind of home or family day care situation where the rules are not so strict. In other words, the young mother may drop the day care center program, including its ancillary services, simply because it is not meeting her needs."

What are the minimal requirements for a quality health program within infant care centers?

* "First, a quality program provides health surveillance. Someone must assume the overall responsibility for looking at the children and noting whether or not they appear to be in good health. This does not necessarily have to occur every day, but regularly enough to ensure the general health and well being of the children. This also involves some kind of record keeping. The staff of the center is going to have to decide what they want to know about their babies, make up a record form and send that record to whomever is delivering health care to the babies--be it a private physician, a children and youth project, a clinic or a hospital. Someone in the center is going to have to take the responsibility for seeing that the information comes back to the center. Minimally, the center is responsible for keeping health records on the children.

"Further, I think centers have a tremendous responsibility to educate caregivers and parents concerning good health care. The mother who did not realize her baby had a broken leg is an example. The center has an absolute obligation to educate parents so that they will be able to recognize what is normal and what is abnormal. These things can be taught and there is as much of an obligation to teach them as to teach principles of cognitive and emotional development."

* "The center must help parents identify backup health facilities in the community. Simply telling the mother to provide good health care for her child will not suffice. Rather, there is an obligation to work with the mother and help her find accessible and satisfactory health care."

* "Finally, the center must have provisions for emergency situations. We cannot expect anyone other than our center personnel to handle an emergency. We must know

precisely what we intend to do about emergency situations before we open the doors of a center, whom we can call in or where we can receive emergency attention."

* "These are the absolute essentials for a quality health program in a center serving infants of young parents. If individual programs are able to go beyond and provide additional services, fine. However, if these services are not provided, then I do not believe that a quality program exists."

Staffing

Infant care centers require staff with particular sensitivity and expertise. The participants discussed the following questions centering around staffing:

When we begin to hire staff for our infant care centers, what type of people are we looking for, what sort of selection process should we use?

* "When interviewing prospective employees, we must keep in mind that we are building a human environment, not just hiring people to take care of children. Therefore, we should look for people who are warm, happy, nurturing, and nonpunitive. Such individuals can come from a variety of backgrounds."

* "It is important to interview people not only in terms of their attitudes toward children, but also in terms of their attitudes toward school-age parents. The reality of the situation is that they will be working with young mothers and fathers."

* "I think it is important to consider the opinions of our young mothers concerning personnel. One method of doing so is to hold a discussion session and ask the young mothers what kinds of people they want working with their children. I did this and found their attitudes were very similar to mine. They want staff members who will care about each individual baby, who will not favor one child over another, who do not have racial biases (we are an integrated group) and who are generally warm and loving."

* "It is very useful to obtain behavior samples in addition to interviewing. If prospective employees are allowed to interact with the children in a center, you can obtain a far better view of how he or she actually behaves with children. It is best to obtain behavioral samples over an extended period of time, since behavior during one or two sessions can be very misleading. You do not simply want to observe the applicants' behavior 'at best.'"

* "Provisional appointments are very useful. For example, we use a system in which we hire staff for a 90-day training period. If the first 90 days turn out to be satisfactory, both for the employee and the center, the new employee is given an additional 90-day probation period. The provisional hiring system seems preferable to all others."

* "Those of us who are planning to open centers and have not had experience in hiring staff should become aware of the resources in the community. Often there are people available who have had experience in hiring personnel for a child-care center. If possible, we should definitely use their services. Further, there may be child-care centers which would permit us to have applicants work with children for a short period of time so we can observe them in an actual child-care setting."

* "Screening procedures are quite difficult, particularly if you cannot make use of the behavioral sample technique or the provisional hiring technique. In my program, we are trying to establish effective screening procedures. We selected seven people out of fifty applicants. To do so, we established a very elaborate system. First we showed films to groups of five or six at a time. These films showed infants and toddlers being cared for in groups. The prospective employees were then asked to distinguish between poor care practices and good care. In addition, we showed films concerning parent behavior and asked provocative questions such as 'What would you do if a girl came in drunk?' Finally, we had individual interviews in which we talked with each applicant about past employment, family attitudes, etc.

"It is very difficult, at this point, to say that there were significant differences between those people we hired and those that we excluded. Obviously, among the original 50 there were some people who definitely were inappropriate for the jobs. But there were some very fine distinctions between those we selected and quite a number of the other applicants."

* "When we established our program, we set up a steering committee. A child development representative was on the committee and it was through her influence that a child development graduate was chosen as director of the center. We have maintained very good ties with a local college child development department and have been able to obtain their recommendations both for the assistant director position and also for volunteer workers."

What are some of the problem areas in staffing?

* "A major problem in school-based programs is that the board of education frequently has the authority to hire staff through the downtown personnel offices. In our particular school-based program we are fortunate enough to have a definite choice of personnel although they are formally hired through the downtown offices. I know this is not the case in some of the other school-based programs."

* "Hiring personnel to work in an infant care center is very risky if it is done by someone not directly related to the program. If staff are imposed upon the program, the situation is at best awkward and at worst potentially harmful to the program and the children."

* "A major problem in hiring staff is the salaries we are able to offer. Most of us operate on very limited budgets. Further, in general we can offer little job security,

since most of our programs are funded by federal, state, or local education or social service monies. Others of us simply exist from year to year on 'package' funding from various agencies or grants. Nevertheless, if my program is representative, we process an astounding number of applications each year. Unfortunately this is primarily due to the poor economic situation. Many of our applicants are unemployed and clearly unsuitable for working with children."

* "It seems to be necessary and desirable to hire a staff that is representative of the ethnic groups served by the program. One of the first questions that our black parents ask when they come to the center is, 'How many black caregivers do you employ?' I think we should place great emphasis on ethnic representation in our hiring practices."

* "In addition to ethnic representation, we should consider hiring staff of varying ages. I am thinking particularly of older people, those within the age range of 55 to 60. Often an older person can temper any hostility which inevitably evolves out of staff interaction. Also, I think they can provide a very stabilizing influence with the young mothers. This is particularly true if the person is from their community, knows their families, and has watched them grow up."

What types of certification are needed for the various staff members in an infant care center?

* "If we make a great effort to provide employment opportunities for members of the communities we serve, we must set some criteria for competence. We should not let this goal override the goal of hiring a competent staff."

* "In the area of education, I have always observed that certification becomes confused with competence. I am sure this extends into other areas such as health and social services. For example, a certified pediatric nurse may or may not be competent, conversely, a person without a certificate may be very competent. We need to be very careful not to exclude people in the population we are serving from working in the centers simply because they don't have certificates of one sort or another. We have an obligation to push for competence and the evidence of competence. This should be the basis for hiring, raises and promotions. My state requires certified educators, a social worker, a health person, and a child development person. I don't disagree that we need all these people, but I would hope we are talking about competent people, not necessarily certified people. There is a big distinction."

What are some of the major issues regarding staff training?

* "Although day care centers are growing in number in this country, there is no specific training available whereby a person can become a competent caregiver or, for that matter, a competent day care center director. It is possible to get a degree

in early childhood education. However, I do not think such a degree necessarily guarantees that a person will be able to successfully direct a day care center, particularly a center for infants."

* "Considering the skills of the various disciplines and professions needed to direct such a program for infants, perhaps a new type of training program should be devised. Such a program could include material from pediatrics, nursing, child development, nutrition and the other relevant fields. I know the training which I received in early childhood education would not have equipped me for the job I am doing now. I have been equipped as a result of my past professional contacts with representatives from many fields, each of which contributed to and broadened my understanding of children and their needs."

* "We should emphasize training the directors of programs. They, in turn, can do their own in-service training. If we bring in outside professional consultants to train caregivers, the director may find that her supervisory capacity is limited and her status with her own staff is reduced."

* "In terms of staff, I feel it is important to have in-service training. However, we should also consider the value of some outside training. When members of my staff have been able to attend workshops, seminars or conferences not directly connected with our program, I have seen a definite change in attitude and motivation. These changes seem to occur more quickly than any changes that occur as a result of in-service training. I think this occurs because additional validation is given to those things which we have taught in training sessions. In other words, staff members observe that other people in other programs are using the same kinds of techniques and principles in working with children."

* "In establishing the practices we use in our center, the main difficulty seems to be with staff members who rely on their previous childrearing experiences. It is simply not effective to say, 'In the center we do things this way.' A frequent response is, 'I reared my children and I have my own way of doing things, which works quite well.' We must deal with the attitudes and feelings the staff bring to the program. The only way to do this effectively is to prove that other ways of interacting with children can be just as useful and rewarding."

* "Many of us work with members of other cultural groups. I think we must consider staff training as a two-way street. We must learn from our staff members while we are simultaneously teaching them the things we know. Many conflicts over discipline, permitting children to have a relatively free environment to explore, and comforting distressed children can be significantly reduced if there is an atmosphere of mutual respect and learning."

* "Many times we cannot anticipate the kinds of values and attitudes people will bring with them when they come to a job. However, we can reduce problems by avoiding classifications such as professional and nonprofessional. A nursery aide or caregiver should not be made to feel that she is a maid. We must develop career opportunities

consisting of meaningful tasks rather than menial tasks. Further, we must provide staff with opportunities for greater responsibility as their skills develop."

* "Many different types of specialists are often required in a center; we should take advantage of this by making a conscious attempt to have the various professionals share their expertise with all staff members. I have a feeling we tend to abdicate responsibility and turn to the nurse or social worker when problems arise within their specialties. Instead, we should be trying to learn from the specialist so we can extend our abilities into all areas."

* "Often we isolate staff members within specific job descriptions. I have a beautiful example of an extension of job definition through the acquisition of new skills and knowledge. We provide transportation for our infants. All the drivers of our vehicles are required to take our child development course. After taking the course and talking with others, one of our drivers developed a series of field trips to 40 different places in the community. These trips focus on important areas of sensory-motor development for infants and toddlers. The driver constructed the series and presented it to the staff as a part of his contribution to the center. This is a concrete example of the usefulness of encouraging each staff member to use his or her capabilities."

What efforts are made to recruit males--especially young fathers--to work in our centers?

* "It seems that most of the positions in a center are automatically filled by women. It could be that the salary level is prohibitive. Whether or not we want to pay men more is questionable, but I do think recruiting males for all kinds of roles is important, and I think there ought to be a great deal more of it."

* "I agree, but from a different standpoint. It occurs to me that the young mothers in our programs probably see very adequate mothering models around them. Yet they rarely see what I would consider a fit fathering model. If they did, they would eventually come to realize that not all men are exploitative and that there are other more appropriate male roles."

* "We have commented previously on the beneficial aspects of having young fathers come into the center to play with the children. We have instituted a more formalized arrangement in which two high school boys from an experimental program come in to work with our toddler group. They were fantastic models for the young mothers and although they could come only one or two days a week, the toddlers just loved them."

* "It has been my experience that once just one father comes to the center to pick up his child, the other fathers begin to follow suit. If we had a male teacher playing with the infants, it would encourage the fathers to play with the infants. I know this has happened in other centers."

What kind of impact does multiple fathering have on a child?

* "We have talked about multiple mothering and the importance of establishing trust. In working with young mothers I see a great deal of multiple fathering. The father has visiting privileges while the mother dates other fellows. Now, we are talking about adding in male day care workers. Will this make the child more sociable or are there other things to consider when there is no stationary male figure in a child's life?"

* "Theoretically, according to research in child development, girls learn their sex role identification from their mothers, but boys learn their sex role identification from the general roles of males in society. The explanation for the sexual identification phenomenon is that a girl is around the mother during the day, as is a boy; neither is around the father. Yet boys do become boys, therefore, the hypothesis is that they learn the role from general male models."

Goals

A quality infant care program should provide the following: an atmosphere of love and nurturing; tasks timed to encourage the infant's emotional and cognitive development; proper monitoring of the infant's nutritional status and health care.

With these goals in mind, the participants discussed specific issues relating to good group care in programs for adolescent mothers.

In providing group care for infants of adolescent parents, should our goals and programs be different from other group infant care programs?

* "Some goals are obvious to those who want to provide quality infant care. However the needs, thoughts and attitudes of some young parents may be quite different from those of older parents. This tends to make our program goals and responsibilities slippery. Our hidden agenda in providing day care services for school-age parents is that we also want to provide additional services for the mother. Further, in serving young mothers, we may have some special problems."

* "I think there is some real confusion about the goals of our programs. If one of our goals is to help the young mother become a better mother, then we cannot operate our centers like parking lots. We have talked about the importance of assisting the young parent in assuming the parental role. We, therefore, have additional responsibilities beyond providing quality care for the infants in our programs."

* "Often young mothers have themselves been reared under an impersonal parenting system. They have not seen infants played with or handled or held while being fed. Our attempts to emphasize the importance of playing with and talking to infants may seem like a lot of 'middle class' foolishness."

* "According to research evidence, there is less spontaneous conversation between mother and infant in lower socio-economic groups than in middle class groups regardless of ethnicity. We have talked about the importance of considering the background and values of the parents, yet we agree it is very important for an infant to experience early communication with the significant adult figures in his life."

If we are faced with a contradiction between the values of the mother and what we believe to be necessary for the healthy growth and development of the infant, how does this relate to our program planning?

* "I think we should get back to some very basic questions about responsibility and power. Beyond the obvious cases of child abuse, who has the right to decide what is appropriate for a particular child? When a child falls down the slide in my center, I always rediscover very quickly that it is the parent who has the ultimate responsibility for that child. When we talk about goals for our programs, we should also talk about whether they are consistent with the goals of the young mothers and their families. We should be asking who makes the final decision about what the goals will be and how they will be implemented."

* "The essential issue is parental vs. program responsibility. We have been describing programs which we hope will have a needed impact upon the mother, but we are avoiding the situations of direct conflict. If we do not devise a means of handling real problem situations, we are going to have programs which run the whole spectrum from reinforcing whatever the mother does, short of child battering, to setting forth rigidly articulated procedures with which we hope the mother will agree."

* "If we react to each mother's own particular way of handling her child, we are going to end up with 40 different coping patterns in caring for 40 different children. Not only would this be an impossible work situation, it would also seem to ignore the tremendous body of knowledge about childrearing assembled by researchers."

* "Actually, we have no choice but to start with the mother's goals. She controls the situation because she is the one who decides whether to allow the baby to come to the center each day. We have to choose between starting where the mother is, and agreeing with her instructions for the care of the child, or never having the child in the center at all."

* "Throughout the whole range of social services, people are beginning to believe that having a service available is not a privilege but a right. Consumers negotiate use of the service; if they become unhappy with the service, they will no longer participate. This is probably very healthy in terms of the consumer, but a neglectful, strong-minded parent can be hard on a child. Parents may be doing some very damaging things with their children but doing them with strong convictions."

* "Many of the students in my program live in settings which contain a great deal of chaos, violence and ugliness. Their children are, of course, involved in all of this.

I think we have to question whether or not we are trying to set up an environment that takes the child away from the home. While I think we must work with the young mother and the family unit to try to alter the negative influences in the child's life and in the young mother's life, we must ask ourselves just how much parental voice we want in our centers. To what extent must we protect a child from his own mother?"

What should we do when the actions of the parents conflict with the needs of the child as we understand them?

* "I feel we must continually make some judgments as to what types of practices will really damage a child. If the practice does not damage the child, we should adhere closely to the parents' ethnic background and value system. For example, almost every culture has songs that mothers traditionally sing to infants. Why not incorporate these songs into our efforts to teach the importance of verbalization? We can attain the same objective by relying heavily on the cultural background of the young mother."

* "One of the major problems we have had in our center is that our view of good care and good stimulation techniques is often seen by our young mothers as spoiling the child. It seems the predominant attitude among young parents is that they want their child to look neat, act correctly and in general be patient and quiet."

* "Among the young mothers in our program, the issue of spoiling comes up quite early in the infant's life. We do not allow babies to be fed by propping a bottle; we insist that they be held. There seems to be no doubt that a baby's feeding experience early in life is extremely important, physically, emotionally, and intellectually. Yet some of our mothers feel that in providing a good experience, we are spoiling their child."

* "The issue of discipline is particularly important when the child becomes a toddler. He should be exploring his world. A 'thou shalt not touch' attitude could be very damaging. If the child is not permitted to reach out into his environment, he will not be motivated to be creative or curious."

* "Frequently our young parents see what is supposed to be a relatively unstructured activity such as simply sitting quietly and playing, and they feel that the children aren't doing anything important. We also get a negative reaction from our parents if they see the toddlers running about. It seems to be very difficult to try to change their attitudes about the importance of quiet and active play. Yet we know this is the only means the young child has of learning about his world."

* "I think the subject of discipline is quite important. This seems to be related to class values rather than ethnic values. Research on childrearing practices suggests that lower socio-economic class parents tend to use more physical discipline with their children. However, in our programs we have been saying we cannot support that particular childrearing practice and certainly will not perpetuate it within our centers."

* "When our young mothers question us about our lack of physical discipline and lack of harsh verbal criticism we simply reply that we are creating a child's world within the center. We tell her we have our way of handling children and she may have a different way. We have found the young mothers are amazed that you can discipline children by distraction or in quiet ways that do not produce physical or verbal conflict. Basically, we are trying to give them role models and it seems to be quite effective."

Is it wise to encourage a child to explore and interact with his environment when we know that his home situation will not permit this type of activity?

* "Many of our toddlers live in very crowded homes where there are many other children. There may be things in the home which are potentially harmful to the child, there may be possessions considered precious to the family. What happens when the child, out of the curiosity we have fostered, harms himself or destroys things within his home?"

* "Really, children can distinguish between one situation and another. In the situation you describe I can see two alternatives; one is to help the mother reduce the possibility of the child hurting himself at home or damaging family possessions, the other is to encourage the young mother to take her child outside each day, under supervision of course. This would produce some physical freedom for the child. Enabling the child to explore his world may help him to better cope with the situation in the home. I don't think we should duplicate the same constraints in our centers that the children experience at home, just as we don't duplicate the use of physical punishment."

Is it ever appropriate for programs to take on the role of child advocate?

* "I sincerely feel we must be advocates for the children. Sometimes we must make choices that will meet the needs of the children rather than the needs of the parents. Young parents, in comparison to their children, have many options. They have social workers, friends, many different people to turn to, while the child may have no one but us. The difficulty is how long we wait before becoming the child's advocate by saying to the young parent or family, 'Look, you are damaging this child.'"

* "In the case of the battered child, I know what to do, separate the mother and the child. Find a place of safety for the child and then begin to work with the mother on her particular problems. However, there is a vast middle ground that is very confusing. When we talk about attachment, and the natural bond between mother and child, we assume in every case such attachment exists. I doubt that we can accept this assumption. Just because a girl decides to keep her baby does not mean that attachment actually exists."

* "If we are aware that there is no attachment, I think we have the responsibility to make some very critical decisions both in the interest of the mother and in the interest

of the child. According to the research, a child who does not experience a significant attachment for an adult will not develop feelings of self worth, and belonging. Certainly the infant can develop an attachment for his caregiver in a day care setting, but we all know this is not going to be a permanent thing. As programmers we must face the issue of what to do if the mother has no attachment for her child but will not relinquish it. Perhaps we can look to the extended family for help, or work with the mother to make her aware that at some point in life she is going to have to take responsibility for her child."

* "When we consider ourselves as child advocates, we had better take a serious look at the legal issues involved in neglect and abuse. Only one state in the country mentions psychological abuse as a just cause for intervention in a parent-child relationship."

* "As a program operator, I am in a position of primary knowledge about poor physical situations concerning some of the children in my center. However, it is not clear to me that I have the responsibility or the power to act on that knowledge. We represent a new type of institution. There is no legitimation of our ability to act even if we know that a child should be removed from a damaging situation. We have to work within the existing systems toward establishing our legitimate primary knowledge so that we will be able to take whatever appropriate steps must be taken."

There are many who feel that providing group care for infants will be damaging for the infants and will destroy the natural bond between a mother and her child. If this is so how can we operate our programs?

* "In our area, we know the girls will be separated from their babies during the course of the day whether they are in the center or not. The only alternative in most cases is for the babies to be cared for in two or three different homes during the course of any given day, and even the homes would vary from day to day."

* "We review very carefully the alternatives each girl has before accepting her baby in our center. Nine times out of ten we have to accept the baby because the alternatives are simply devastating for that child."

* "Some recent research has produced some interesting correlations. This research was based on a low-income population. It demonstrated that mothers who were working, or had gone back to school and who seemed to be fulfilling some of their own needs actually had a higher quality of interaction with their children. On the other hand, the mothers who were spending more time with their children in the home were not necessarily spending that time interacting well with their children. This is, of course, a gross generalization but it seems that the quality of interaction and not the quantity of interaction is the most important issue. Since this research was with a low-income group,

it may be that the reality of the economic situation was the critical factor. If these mothers were going to provide a good environment for their children, they had to work. Therefore, the mother who was most motivated to provide for her child was compelled to be out of the home a great deal."

* "Also, it seems there are qualitatively different kinds of separations. If the infant is in a school situation in which the mother can participate at certain points during the day, it is quite different than placing the infant in a center while the mother works eight hours a day."

* "We can conclude that if a young mother is going to engage in quality interaction with her child in whatever brief time she has with him, she has to feel some success somewhere else in her life. We must plan our programs to help her gain some feelings of self worth and confidence."

* "The teenage girl's need to achieve her own developmental level and her own developmental goals may interfere with her ability to perform as a mother. On the other hand, the extent to which she is successful in achieving her own developmental goals probably enhances her potential as a mother."

* "We have to be very clear about what we are doing here because we are working from a limited knowledge base. Research is in progress, but until we have the results we must be a little cautious. We know an infant needs to develop an attachment with an adult in order to develop and grow. If our goal is to develop a firm attachment to the mother and allow the mother to take on her appropriate role in rearing the child to adulthood, we must keep that goal firmly in mind. In designing our programs, we must be careful not to become so involved with the needs of the mother that the needs of the infant become an afterthought. We must be clear about what we are doing to these two very important individuals whose relationship to one another is the most critical issue."

Alternate Models

Although group care for infants was the predominant model used in the programs represented at the workshops, participants also considered the advantages and disadvantages of alternate models such as family day care, paid babysitters, etc. It was pointed out, for example, that when a child is cared for in the home, either by a babysitter or by a relative, the main advantage is physical convenience; it is not necessary to move the child. When the child is ill, the question of whether or not the mother must stay home does not arise in most instances.

In considering family day care, some of its advantages include the provision of a home atmosphere and a situation in which small numbers of children are grouped together. The disadvantages appear to stem from a general lack of supervision in the family day

care situation. Money is also a factor; programs would have to obtain additional financial assistance in order to help young mothers use family day care as a viable alternative.

Some of the questions discussed by participants were:

What types of child care arrangements, other than group care, could the young mother use successfully?

* "We made quite an extensive study of licensed day care homes in our city and found a variety of things. First, the health and fire regulations were so prohibitive that by the time the requirements for a license were met, the family day care mother had made a significant monetary investment. Moreover, since the money she could make caring for children was quite low in comparison to the original overhead costs, making ends meet was almost impossible. At the same time, the demand for care of children in licensed homes was so high there was a very long waiting list. As a result, many children were being cared for in unlicensed homes where conditions were quite poor."

* "Through a Model Cities grant, our community established a number of family day care homes. Money was provided for conversion of the home to meet the required standards; training was provided for the day care mothers and they were paid an adequate salary. These are very good homes that are meeting a definite need. However, if you consider the limited number of children that can be cared for in these homes, it seems impossible that they can provide services for all of the infants and children needing care."

* "My experience with licensed day care homes has, for the most part, been negative. If a public agency intends to supervise these homes, we must insist they visit the homes regularly. Inspection visits should be unscheduled so the actual conditions within the family day care home can be observed. There are some very brutalizing things going on behind some of those doors. Group care facilities should also be strictly supervised. I feel we are proceeding with plans without setting up the processes whereby we can follow through with effective supervision of the quality of care children are receiving. We may be setting up situations which have inherent negative possibilities."

* "We began by using family day care for our young mothers. Our principal problem was the inconsistent actions of the young mothers. They did not bring the necessary supplies for the baby to the home; they were generally inconsistent in the times they left or picked up the baby. The family day care mothers simply could not cope with this and, as a result, there was a constant turnover in the day care homes used by the young mothers. Perhaps we could have alleviated the difficulties through a special education program for the young mothers. However, we have since opened an infant care center and incorporated the educational program within the center."

* "We should be specific. We are talking about adolescent mothers. I have questioned the young mothers in my program; each wrote a composition about her preferences. The overwhelming majority stated they did not really trust a family day care mother; they felt more confident placing their children in day care centers where there were 'professional' personnel."

* "In contrast, I have asked the young mothers in my program how they feel about the possibility of opening an infant care center, as opposed to having their families or a neighbor take care of their babies. Most of the young mothers were reluctant to have their babies cared for in a center. This reluctance seemed to be based primarily upon the difficulties involved in transporting the child to and from the center while simultaneously trying to attend school. They indicated they would prefer to have their babies cared for in their communities, as close to their homes as possible. Their second option was to have a day care center located within their regular high schools."

* "I think most of us in this room have seriously considered putting our own children into the home of a relative or friend--someone we felt would give the child the kind of warmth and care needed. We would probably prefer this as an alternative to group infant care. This form of alternate care, as well as hiring babysitters, is frequently used by middle and lower income parents. Our objective should be to find ways of making this type of care meet the needs of very young parents."

Is there any way we can make family day care a more attractive alternative for young parents?

* "We have developed a more or less informal family day care arrangement through our program. Among our girls, there are always several grandmothers who do not work and are quite competent in caring for children. We identify these grandmothers and, since they will be caring for their grandchild in any event, we ask if they will care for one or two additional infants. We pay them for this service. In this way the young mothers seem to have confidence in the care their infants are receiving because the mother of one of their friends is giving that care."

* "We seem to have said family day care is not a viable alternative based on our previous experiences. However, I would like to point out that little or no effort has been made to provide the family day care mother with training, status, or a living wage. Researchers have largely ignored her while concentrating on the means of selection, personal qualities and ways of training caregivers for group centers. The family day care mother has been treated simply as a woman who takes in children."

* "We seem to assume there is no way to improve the family day care situation. We don't seem to be willing to give as much attention to developing good family day care as we give to developing good group care. Actually, everything we have said about quality group care could easily apply to good family day care. I think we could build an educational component into a family day care operation. The child would be

close to the mother's home and a properly trained family day care mother could provide an excellent model for the young mother. Although not many programs are moving in this direction, it is a viable alternative."

* "At least one program for young mothers has successfully used family day care homes in the community. The professionals in the program work continuously with both the young mothers and the family day care mothers. Care for the infants is purchased for the young mothers by the program."

What type of infant care best lends itself to teaching parenting skills?

* "I am interested in working with the young parent and teaching the young parent. The child care we offer is a beneficial service, and we attempt to deliver high quality care. However, the thrust of the program is working with young parents."

* "A day care center seems to provide a stabilizing force for many young mothers, particularly those who have been living alone or for whom life has been traumatic and unstable. The young mother is not just a mother, she is a student and has additional social and emotional needs that a properly organized center can meet. The young mothers in my program sit around our living room area and discuss homework assignments, what went on in school, and other aspects of their lives unrelated to their babies. When they do discuss their babies and the difficulties of being a mother, I have an opportunity to help them assume this new role which they must carry along with all of the other normal adolescent roles."

* "I think we agree that the adolescent parent has different needs than older parents. If we thought family day care was the best means of delivering services, we would take the money we are putting into group care and spend it on improving family day care services, since family day care is less expensive than providing quality group care."

* "I think it would be a terrible mistake to follow a set pattern. We want to provide high quality care for infants and we are tremendously involved in teaching parenting skills. But I think a variety of program models can provide these services. I don't think we need to talk about this type of program as opposed to that type of program. I think it is entirely possible for us to put the same kind of will and experience into the development of alternate program models. Not every infant and not every mother has the same kinds of needs or will profit most by a particular type of program."

* "I think we must work with all of these models. We should create a system which recognizes the legitimacy of all types of alternate care plans by creating outreach such as home visitor/teachers, toy lending libraries, subsidizing care and maintaining continued contact with the young mother. I know we are all doing more than we can afford to do already, but if we really want to meet the needs of the community, we are going to have to work through a variety of systems in order to bring young mothers back into school and provide quality care for their children."

Should we limit our efforts in our communities to those children and young parents we feel able to serve directly?

* "People who work with children work for children. I believe that those of us who are concerned about child care have to recognize the right of every child to have quality care. As a result, I think those who are working in this field are going to have to use a variety of means not only to work with the children who are under our particular guidance, but to act as advocates for children who are not receiving adequate care. Further, a variety of ways to provide child care will have to be explored. Our centers simply do not have the space, personnel, or money to serve all the children in our various communities who need quality day care, but we can be advocates for children and work with other groups to see that additional facilities for children are established."

* "We must attempt to bring about more interagency action. Agencies have a way of trying to build on their own power base without focusing on the total needs of the people they serve. We need to establish ways of working as a group to solve interrelated problems."

* "If we institute a group center program, we must face the question of how best to serve as a resource for other people. If we intend to serve as a resource for other people, specifically what people? Should we serve people who are using family day care on a formal basis or an informal basis? By formal I mean care given to a child in a licensed home and paid for; by informal I mean that the child is cared for in somebody else's home without the exchange of money. Should we serve as a resource for the home babysitter, or for the family member who is caring for the child ? I think we should discuss ways in which a group care program could work with these other forms of care for mutual advantage."

* "Through my experience with a research and demonstration day care center, I have found that people need a great deal of flexibility. Their needs change from time to time. People change jobs; people go out of one kind of training program and into another. Child care services may be needed at a different time of day; sometimes they need half-day care; sometimes they need full-day care, and so forth. It would be best for a community to set up a central organization with two functions: 1) an information service to people who need care, and 2) an inspection service, reporting on centers, family day care homes, or any community people involved in providing child care. Even babysitters would be licensed by this central organization. This would provide the needed safeguards and the needed flexibility."

* "We must find ways of mobilizing the resources of our country to meet the pressing needs of all children and their parents. In these last few years a few communities, perhaps 250 at most, have recognized the needs of school-age parents and attempted to formulate programs that will help them attain their rightful place in our society. However, we are far from our ultimate goal of providing services for all school-age parents and their infants."

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